# Outpatient Chart Manual


If you have any comments or questions regarding any of our webpage contents, contact us via email: pmuquestions@dbh.sbcounty.gov

# Introduction

| | |
|---|---|
| **Services** | The Outpatient Chart Manual applies to all non-patient services whose medical records are governed by Medi-Cal requirements. This includes all of the Department's outpatient, day treatment, case management, and medication services. |
| **Manual priority** | This manual, rather than the **Department's Standard Practice Manual**, governs charting and record keeping in the Department. |
| **Manual Maintenance** | The Department's Clinical Records Committee maintains the Manual. Revisions are issued periodically, and it is important to file them appropriately so that your Manual is up-to-date.<br><br>If you find things in the Manual that are not clear, or look for things in the Manual but cannot find them, please inform the Committee so that we can improve the Manual. |

# Care Necessity Form

**Purpose**

The Care Necessity form provides documentation of the Departmental and programmatic reasons why an individual qualifies for Department services.

**Procedure for Completion**

The following procedure is followed when completing this form:

| Step | Action |
|---|---|
| 1. | Complete the form upon admission during the intake period.<br><br>**Note:** As of 4/03 there is no requirement for routine repeated completion of the form following the initial intake period. |
| 2. | Check all boxes that apply to the client, even if the client does not currently have the type of coverage implied. |
| 3. | Update the form as coverages change. |
| 4. | The form must be signed by an LPHA:<br><br>• M.D.<br>• Registered Nurse<br>• Licensed or Waivered Psychologist<br>• Social Worker<br>• MFT<br><br>**Note:** The form may be prepared for LPHA signature by other staff. |

# Client Resource Evaluation

**Purpose**

The Client Resource Evaluation is completed on the first or the second client visit to identify basic resource needs, so that efforts can be made immediately to help client's obtain needed resources.

**Form completion**

The following considerations are made when completing the **Client Resource Evaluation:**

- The client's sense of what his/her needs are is the basis of the evaluation (which includes what the client views as appropriate in his/her culture)
  - Staff may, however, identify needs that the client denies due to fear or psychopathology, even though the client refuses help with these needs at the time.
- In each section check "no need", or describe how the:
  - Need is currently being met;
  - Any additional need level, and
  - An initial plan for how to meet that need better.
- Obtain the client's signature on the form, if possible. The client may be given a copy of the completed form

# Diagnosis

**Requirement**

A complete 5-axis DSM-4 diagnosis is required and must be:

- Written out in full with:
  - Code numbers
  - Diagnosis names
  - All applicable qualifiers

Additionally, the diagnosis must be

- Consistent with
- Supported by
- Descriptive of the history and symptoms detailed in the **Clinical Assessment**

**Initial Time Frame**

The following time requirements apply to the diagnosis:

- No billing can be done without a diagnosis, so a diagnosis must be made on the first visit (including an initial medications visit), even if it is provisional
- This diagnosis must be entered on the blue diagnosis page dated before or on the date of the first billable service
- A physician or clinician may complete the initial diagnosis

**Official diagnosis**

The official diagnosis of a client is the diagnosis on the diagnosis "blue" sheet, which is the third page of the treatment–related blue pages in the front of the chart.

- Any clinician or physician wishing to change that diagnosis must make the change on that page, with appropriate coordination with other open charts for the client
  - (See **UNIFORMITY OF DIAGNOSIS IN MULTIPLE OPEN CHARTS** below.)

**Important:** A diagnosis entered in an **ID note** without a change of diagnosis on the diagnosis page is ***not*** an operative diagnosis

**Axis IV**

The client's specific psychosocial and environmental problems are:

- Written out, in descending order of severity
  - (The problem categories (e.g. "Problems with Primary Support Group") are not used on Axis IV in the chart)
- Not given a numerical rating on Axis IV
  - (The SIMON entry for Axis IV can be "J" for unknown
  - "A" through "I" for the categories of problems listed in **DSM- 4**

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**Axis V**

The following are requirements for Axis V:

- A current GAF is required on Axis V
- GAF ratings for other time periods may be added, at the clinician's discretion
  - (The SIMON entry for the second Axis V field is "00" for unknown or the numerical rating for "highest past year" functioning.)

**Provisional and Rule-Out Diagnoses**

Any provisional, deferred, or rule-out diagnoses must be clarified within 60 days after they are fist given.

**Deferred or V71.09 Diagnoses**

The SIMON system will accept a deferred diagnosis (799.90) on either Axis I or Axis II (but not both) on opening an episode, but will not accept a deferred diagnosis on closing an episode.

"No diagnosis" (V71.09) will be accepted by SIMON on either Axis I or Axis II (but not on both), for opening and closing

<table>
<tr><th>If the true diagnosis is …</th><th>Then…</th></tr>
<tr><td>V71.09 on both Axis I and Axis II,</td><td>Enter these true diagnoses in the chart.</td></tr>
<tr><td></td><td>
<table>
<tr><th>If…</th><th>Then enter…</th></tr>
<tr><td>Opening in SIMON when the true diagnosis is V71.09 on both Axis I and I</td><td>Enter 799.9 on Axis I and V71.09 on Axis II.</td></tr>
<tr><td>Closing in SIMON when the true diagnosis is V71.09 on both Axis I and II,</td><td>Enter V71.9 on Axis I and V71.09 on Axis II.</td></tr>
</table>
</td></tr>
<tr><td colspan="2">SIMON staff will convert the V71.9 to V71.09.</td></tr>
</table>

**Substance Use and Mental Retardation**

The Department will not usually be reimbursed for treatment of persons with principal diagnoses of alcohol or drug problems or mental retardation, so some other mental disorder should be the principal or billing diagnosis. Substance use and mental retardation diagnoses can be appropriate secondary diagnoses.

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**Ensuring that all Secondary Diagnoses are made**

All applicable diagnoses **ARE** to be made (especially substance diagnoses), since this is the only way that our management information system can provide accurate information for program planning. Substance-related and mental retardation diagnoses should not be primary or billing diagnoses for mental health billing (although substance-related diagnoses are primary billing diagnoses for ADS).

**Organic Mental Disorders**

The following are considerations when charting the diagnosis of a client with an organic mental disorder:

- If organic mental disorders are treated, the treatment must be recognized and potentially effective mode of treatment for the aspects or sequelae of the organic disorder that are being treated (such as depression secondary to cognitive dysfunction)
- Add all appropriate Axis III entries needed in conjunction with an Organic Mental Disorder diagnosis

**Co-Signature: staff authorized to diagnose**

The diagnosis and any changes in diagnosis must be co-signed by a person qualified to diagnose, if the person completing the assessment is not so qualified. The following staff are the only ones authorized to co-sign:

- Licensed M.D.'s
- Clinical Therapists
- Clinic Supervisors
- Program Managers

**Consistency of Diagnosis with medications**

Physicians will ensure that the diagnosis on the blue Diagnosis sheet is consistent with medications being prescribed.
As of 8/21/02, there is no longer a requirement:

- For an Annual M.D. signature on the Diagnosis sheet
- That clients not receiving meds be reviewed annually

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**Uniformity of Diagnosis in multiple open charts**

All service sites must operate under a uniform diagnosis for any given client. This diagnosis will normally be the diagnosis in the chart that was opened first among the currently open chart (episodes) for that client. This concept is demonstrated by the following procedure:

| Step | Action |
|---|---|
| 1. | When other sites open charts on a client, they will:<br>• Obtain a copy of the **Diagnosis** sheet from the first opened chart (if there are other currently open charts), and<br>• Will either use the diagnosis as is, or confer with the first opened clinic regarding any changes in diagnosis. |
| 2. | Discuss the situation with the first-opened clinic, if staff wishes later to change the diagnosis. |
| 3. | Reach diagnostic consensus with all provider sites so that there is a consistent diagnosis in all client charts at any given time. |
| 4. | Involve treatment teams in diagnostic discussions to reach consensus, if necessary. |

**Using the form and changing a diagnosis**

The **Diagnosis** form is used in the following ways when changing a diagnosis:

- The form contains sections for two complete diagnoses. Any change in diagnosis requires re-writing the diagnosis in full, using either the second section on the form, or a new Diagnosis sheet with the same date and a signature below
- A “P” is placed in front of the code number of the principal diagnosis, if that principal diagnosis is not the first diagnosis on Axis I

**Professional disagreement on diagnosis**

Diagnoses may be changed by clinicians or by physicians, however the following guidelines must be adhered to:

- Consultation must occur regarding the most appropriate diagnoses
- Neither clinicians nor physicians should by implication invalidate the treatment that the other is providing by changing a diagnosis without consultation
- DSM-4 criteria will serve as the bases for diagnosis in all cases
- Diagnostic disagreements which cannot be resolved may be appealed in the chain of command, with final decision by the Chief of Medical services

**Explanatory note**

Changes in Axes I or II must be explained in a regular session note or in a separate ID note labeled “Diagnosis Change” on the same date as the diagnostic change.

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| | |
|---|---|
| **Annual update** | There is no requirement for a scheduled diagnosis update. The diagnosis will be updated as needed in conformance with the client's condition. |
| **Principal diagnoses which meet Medi-Cal medical necessity rules** | **Attachment 1** identifies those diagnoses that are acceptable as principal diagnoses in justifying treatment according to Medi-Cal's medical necessity criteria. (The other, "excluded" diagnoses may still be present as non-treated secondary diagnoses if an "included" diagnosis is the principal diagnosis.) |
| **Diagnoses from other facilities** | If it is necessary for a staff person who is not qualified to determine a diagnosis to open an episode with only in-the-field contact (no clinic visit), the episode may be opened using a copy of a written diagnosis made within the last 45 days by another reputable institution inpatient hospital, clinic, etc. The DBH Diagnosis sheet must be completed within the intake period by a person qualified to diagnose. |

# Included and Excluded DSM-4 Diagnoses for Medi-Cal Specialty Mental Health Services (Adults and Children) 3/98

**Accepted/ included diagnoses**

The following is a listing of diagnoses accepted/included as principal diagnoses as the focus of treatment. **Note:** the listing of a DSM- 4 section below, such as Elimination Disorders, refers to all diagnoses in that section.

| |
|---|
| Pervasive Developmental Disorders Except Autistic Disorder |
| Attention-Deficit and Disruptive Behavior Disorders |
| Feeding and Eating Disorders of Infancy and Early Childhood |
| Elimination Disorders |
| Other Disorders of Infancy, Childhood or Adolescence |
| Schizophrenia and Other Psychotic Disorders |
| Mood Disorders |
| Anxiety Disorders |
| Somatoform Disorders |
| Factitious Disorders |
| Dissociative Disorders |
| Paraphilias |
| Gender Identity Disorder |
| Eating Disorders |
| Impulse Control Disorders Not Elsewhere Classified |
| Adjustment Disorders |
| Personality Disorders (except Antisocial Personality Disorder) |
| Medication-Induced Movement Disorders (if related to other included diagnoses) |

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# Included and Excluded DSM-4 Diagnoses for Medi-Cal Specialty Mental Health Services (Adults and Children) 3/98,
Continued

**Not Accepted/ Excluded diagnoses**

The following is a listing of diagnoses not accepted/excluded as principal diagnoses as the focus of treatment:

| |
|---|
| Mental Retardation |
| Learning Disorders |
| Motor Skills Disorder |
| Communication Disorders |
| Autistic Disorder |
| Tic Disorder |
| Delirium, Dementia, and Amnestic and other Cognitive Disorders |
| Mental Disorders Due to General Medical Condition Not Elsewhere Classified |
| Substance-Related Disorders |
| Sexual Dysfunctions |
| Sleep Disorders |
| Antisocial Personality Disorder |
| Psychological Factors Affecting Medical Condition |
| Adverse Effects of Medication NOS |
| Relational Problems (V-Codes) |
| Problems Related to abuse or Neglect (V-Codes and others) |
| Additional Conditions That May be a Focus of Clinical Attention (V-Codes and others |

**Note**

A client who has medical necessity may receive treatment for an included diagnosis even if the client also has an excluded diagnosis.

# Initial Contact Form

**Policy**

The current, approved **Initial Contact Form** will be used by all DBH sties as the basic tool for gathering information from potential clients upon first contact.

**Note:** See the DBH SPM for procedures and all required forms for that initial contact.

**Procedure for completion**

The following procedure shall be followed when completing the **Initial Contact Form.**

| If the potential client … | Then the potential client may … |
|---|---|
| Is able and cooperative, | Be asked to fill out the form on their own. Clerical staff may assist them in completing this form. |
| Unable to complete the form or refuses to do so, | Not be required to complete the form. The client's inability or refusal to complete the form will not be used as a reason not to evaluate the person. |
| Staff will gather only information needed for their own tasks, using or not using the form. | |

# Medical Necessity

| | |
|---|---|
| **Criteria** | The Medi-Cal medical necessity criteria are printed in the Care Necessity form. Each client must be evaluated with regard to medical necessity when the client is first seen. Changes in medical necessity must be documented in the ID notes |
| **Clients not meeting medical necessity** | See current Department policy regarding whether any services may be provided to those who do not meet Medi-Cal medical necessity criteria. |

# Closing the Chart

**Definition**

A chart is “closed” when all services at that site are terminated.

**Intake period closure**

If a chart is closed within the initial two-month intake period, then the Clinical Assessment, Client Plan, and Discharge Summary need not be completed. (The Care Necessity form and Diagnosis sheet should be completed for every client if enough information has been gathered to enable completing these forms.)

Treatment delivered without these completed forms must be appropriately justified by the:

- Description in the chart of the client’s problems and medical necessity
- ID notes
- Partially completed Clinical Assessment

Charts with a recorded "no-show” after the intake period must have all of the usual paperwork elements mentioned above completed.

**Timing of SIMON closures**

Since open episodes are necessary for billing, episodes should not be closed in SIMON until all case billing has been completed.

**Documentation**

In all cases there will be:

- A closing ID note, noting the fact of the closure.

| If the… | And… | Then… |
|---|---|---|
| Chart is closed during the intake period, | Discharge Summary form is not used, | This ID note will include the:<br>• Reason for the client’s treatment<br>• Course of treatment<br>• Reason for discharge<br>• Client’s condition on discharge |
| Chart is closed with only one service | There is no clinical discussion of the closure needed in the closing ID note | A clerk may write the closing ID note, but it must be co-signed by the Clinic Supervisor |

# Schedule of Essential Chart Forms and Due Dates

| | |
|---|---|
| **Introduction** | The following documents are required in all client charts by the due dates noted. |
| **Prior to any billing** | Diagnosis sheet completed and dated before or on the date of the first billable service is required. |
| **By the end of the first two months** | The following documents are required:<br>• Clinical Assessment<br>• Care Necessity form<br>• Diagnosis sheet (must be completed at the time of the first visit)<br>• Outpatient Consent form<br>• Advance Directives form<br>• Client Resource Evaluation<br>• Client Recovery Plan |
| **In the 30 days following the start of a new service** | Client Plan for that new service is required |
| **In the 30 days before the end of every services period** | A new (re-written) Client Plan for any continuing services is required. |
| **As needed** | The following documents are required as needed:<br>• Update of Diagnosis sheet, when changes occur<br>• Update of Clinical Assessment, when appropriate<br>• Update of Care Necessity criteria, when appropriate<br>• Update of Client Plan elements, when appropriate |
| **Charts including medication(s)** | For charts that include medication(s), include all of the above-mentioned documents as well as the following. |

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# Schedule of Essential Chart Forms and Due Dates, Continued

| | |
|---|---|
| **By the end of the first two months** | Chart must include:<br>• Medications Consent form (when medications are started)<br>• Physical Assessment form<br>• AIMS form |
| **Annually In the first 30 days before the DOE anniversary date** | Chart must include:<br>• Update of Physical Assessment and AIMS forms<br>• New Client Plan for MSS (unless not expiring because already done in last 12 months) |
| **As needed** | Chart must include the following as needed:<br>• Update of Medications Consent form and client signature (when medications change)<br>• Update of meds plan as appropriate in Client Plan<br>• M.D. check diagnosis to ensure consistency with medications given |

# Time Period Definitions

**Definitions**

The following chart provides time period definitions used in charting.

| Time Period Name | Definition |
|---|---|
| Date of Entry (DOE) | The date of opening of the episode. This is sometimes called the "date of registration" |
| Intake Period | The two-month period starting with the date of entry. |

| If the … | Then the… |
|---|---|
| Client's date of entry is 2/15/95 | End of the intake period is 4/14/95. |
| (For an entry date of 12/30 or 12/31, the end of the intake period is the last day of February) | |

| Annual Period | Exactly twelve (12) complete months, starting on the date of entry: |
|---|---|

| If the date of entry is… | Then the annual period is… |
|---|---|
| 12/13/01 | 12/13/01 through 12/12/02 |

| Annual Window Period | The twelfth month of the annual period- the month period prior to the end of the annual period: |
|---|---|

| If the annual period … | Then … |
|---|---|
| Started 9/16/00 and end 9/15/01 | The window period is 8/16/01 through 9/15/01. |

| Authorization Window Period | The month period prior to the expiration of an authorization: |
|---|---|

| If the authorization period is… | Then the window period for re-authorization is… |
|---|---|
| 8/2/00 – 11/1/00 | 10/2/00 – 11/1/00 |

# Transfer Paperwork

**Transfer episode defined**

When a client transfers from one site to another, a new episode is opened at the new site.

A transfer is considered a transfer under this section if there is a gap of no more than one month between the closing of the first clinics' episode and the opening of the second clinic's episode.

**Documents transferred**

To facilitate this transfer, the first clinic will send the second clinic copies of the most recent:

- SIMON Registration form
- Outpatient Consent for Treatment
- Diagnosis Sheet
- Clinical Assessment
- Medicare Affirmation and Notice
- CalWORKS check sheet and JESD release (if present)
- Client Plan
- Care Necessity form
- Meds Order sheet
- Client Resource Evaluation
- Discharge Summary

**Document distribution**

Transfer documents are distributed in the following manner:

- Originals will remain in the first clinic's chart.
- Copies will be a permanent part of the new chart and will be marked as follows: **COPY STAYS IN [name of clinic] EPISODE.**

**Second clinic responsibilities**

The second clinic does not need to re-do the following forms:

- Clerical (blue) Initial Contact form
- SIMON registrations
- Care Necessity form
- Outpatient Consent for Treatment

But will re-do the following forms:

- Episode Opening form (SIMON)
- Meds Consent for Treatment
- Client Plan (if the current Plan is not used)

The second clinic will add new information, if applicable, to the clinical Assessment (or complete the Clinical Assessment Update).

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**Form completion schedule**

Forms that are transferred to the new chart by copy will then be on a completion schedule determined by the new date of registration.

**Chart closure**

When a chart is closed and episoded, the following steps occur:

| Step | Who completes | Action |
|---|---|---|
| 1. | First clinic | Sends the chart itself to Medical Records in the BHRC. |
| 2. | Medical Records | Sends that episode on to the new clinic as needed. |

**Concurrent Episodes**

The same procedures stated above apply when a client starts services at a new site and the previous clinic continues its services,

**Unanticipated services provided at another site**

When another site (where the client does not have an open episode) provides an unanticipated service to a client, the clinic with the client's already open episode will provide appropriate paperwork to the second clinic, by fax if necessary.

In the case of an **emergency meds service**, this consists of copies of the:

- Client's meds order sheet
- Last MD ID note

**Note:** If a service is provided at a site without an open episode, a copy of a chart note for that service will be sent to the client's regular clinic.

# Transfers

**Policy**

When an episode is to be closed and the client transferred to another DBH or contract unit, all providers at the current site are consulted before the decision to close is made.

| If… | Then the… |
|---|---|
| There are questions about the appropriateness of transfer, or | Supervisor or Team is consulted. |
| Providers disagree about closure, | |

**New Site**

The site of new services consulted. Use the **"IF/Then"** table for possible outcomes:

| If… | Then… |
|---|---|
| That site does not wish to accept transfer, | The respective Program Managers can be re quested to work out the problem. |
| Receiving Clinic Supervisor or Team agrees to the transfer, | An appointment may be made for the client at the receiving clinic. |

**Discharge summary**

The following procedure is followed when the discharge has been approved:

| Step | Action |
|---|---|
| 1. | A Discharge Summary is done, if the case has been open at the site for more than 60 days, and |
| 2. | The chart episode is closed before transfer, and |
| 3. | The episode is closed in SIMON. (This closure need not be coordinated with other sites.) |
| 4. | The chart is then sent to Central Medical Records, which will send it on to the receiving clinic. |

# Dual-Diagnosis Services in DBH Outpatient Clinics

**Definition**

Dual-diagnosis services may be provided for clients with both mental illness and substance-related problems.

**Focus of service**

Dual-diagnosis services provided by the mental health clinics of the Department of Behavioral Health ***must focus*** on the mental/behavioral health needs of the client. Dealing with mental/behavioral health concepts and needs is acceptable including how the client:

- Recognizes and attempts to meet needs
- Deals with emotions
- Makes plans
- Carries out responsibilities, etc.

| If… | Then… |
|---|---|
| Services provided which ***focus on sobriety or dealing with aspects of the client's substance use or dependence*** (whether to use, how much to use, how to quite, etc) | Services will be subject to ***audit disallowance.*** |

**Diagnosis**

Substance-related diagnoses must be secondary diagnoses for these clients.

**Dual-Diagnosis groups**

Billable groups of dual-diagnosis clients must be either:

- Rehab-ADL groups (MHS-rehab/ADL-group)
- Psychotherapy groups (MHS-group)

Only these services may be provided to clients in these groups. Charting and billing clients in these groups for Collateral or Case Management (instead of for group) is not allowed.

# AB3632 Clinical Assessment

**Purpose**

An adaptation of the Clinical Assessment has been designed to serve for **AB3632** cases as both a Clinical Assessment and an **AB3632** assessment.

**Instructions**

The same instructions as in the **Clinical Assessment** section apply to filling out the AB3632 Clinical Assessment. Instructions for the specifically **AB3632** section regarding the following topics:

- Reports of records
- Interviews
- Testing
- Eligibility

Can be found in the **AB3632** manual.

**Distribution of Assessment**

The following steps are followed in distributing of the **AB3632** Clinical Assessment to the school:

| Sent to the School | Not Sent to School (Retained at DBH) |
|---|---|
| • First five pages of the **AB3632** Clinical Assessment as an AB3632 assessment<br>• A copy of the MHS Service Plan | • The Mental Status section of the **AB3632** Clinical Assessment and<br>• Final page of the intake |

# Clinical Assessment – Adult and Child/Adolescent

**Structure**

The Clinical Assessment has two sections. The first two pages are the screening/triage form, and the second part provides additional assessment information about the client. Each section has certain labeled parts that must be filled out by an LPHA. Each section may be billed separately (or the two may be billed as a unit).

There are two versions of the Clinical Assessment--one for adults and one for children up to 18.

**Time Frame**

All sections of the Clinical Assessment (intake) are completed during the initial intake period, before the Client Plan is done, and they are stapled together and placed under the Assessment tab at the end of the chart. It is updated at any point if additional significant information becomes available and if the clinical picture changes significantly enough that the first assessment is not consistent with current treatment.

**Use of Previous Assessments**

If an episode is opened, and the previous Clinical Assessment (or similarly complete assessment from another facility) is less than two years old, an update may be done. The previous intake is stapled behind a fresh Clinical Assessment form. On this fresh Clinical Assessment form, update various sections as needed, and write, "see previous intake attached" in sections where information is unchanged. In all cases, the sections for Presenting Problem and Mental Status must be done completely anew. If an episode is opened, and the previous Clinical Assessment is more than two years old, then a new, complete Clinical Assessment is done.

**Additional information during an episode**

If additional assessment information becomes known during an episode, it is written on the final page of the Clinical Assessment, which is labeled Assessment Update, with the writer's signature and date.

**When the form is filled up.**

If there is not enough room on the form for additional information, insert the needed single blank page of the Assessment into the page sequence, immediately in front of the already full page, write "ADDENDUM" beside the page number at the bottom of the page, and enter any new or changed information, with the date and the writer's initials, and a signature in the Assessment signature block with that date. (To add information to the already-printed on-screen version, type or write it on a blank piece of paper, labeled with the client's name, chart number, date of birth, and program name, date and sign it (along with your printed name), and add it to the Clinical Assessment.)

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**Completing the form**

ALL sections and items must be completed for the assessment to be considered adequate. Enter N/A if the item is somehow not applicable, or "N/AV" if the information is not available (e.g., because the client or collateral persons cannot give the information). In general, checking "None" or "No problem" eliminates the need for a written entry for that item, whereas checking that some aspect of the item is present does require a written explanation if space for writing is provided. The goal is a Clinical Assessment that describes the client in depth and comprehensively, that illustrates any medical necessity present, and that provides a good symptomatic and historical basis for a DSM-4 diagnosis.

A. MARITAL STATUS: "S M D W Sep" stand for single, married, divorced, widowed, and separated. Note the client's current status.

B. "Lives In/With" refers to the client's living arrangement.

C. PRESENTING PROBLEM: Include when the presenting problems began and what behaviors or circumstances led to the need for the present assessment. Describe problems in daily functioning, such as with responsibilities, social relations, living arrangement, and health.

D. SUBSTANCE USE: Ask initial questions assuming that the client has used substances ("When was the last time...?" rather than "Have you ever...?"), since that is more likely to produce important information. If the client consistently indicates not using a substance, then later questions in the sequence become less relevant for that substance.

E. MOTIVATION AND REASONS FOR TREATMENT: These questions are intended to help the treatment teams assess what the client is adequately motivated to do in treatment.

F. CULTURAL ISSUES: Follow the instructions regarding the screen questions. If a more thorough assessment for cultural or sexual orientation issues is indicated, there are guideline questions available. It is assumed that understanding every client's cultural background and other diversity issues is necessary in order to provide effective care, so cultural/diversity information relevant to treatment should always be entered if known. If a more thorough assessment is done, it is written on pink ID note pages or typed on white paper and inserted after page 2.

G. FAMILY SUPPORT: Determine from the two questions whether the family's support and involvement are important (or necessary) to the client, and whether the client would like to have family involved in some way in his/her treatment.

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**Completing the form** (continued)

H. MENTAL STATUS:

1. THOUGHT PROCESS means the general quality and adequacy of understanding, reasoning, planning, and other cognitive processes.
2. DELUSIONS. Troublesome thought content, including delusions, is described under Thought Content/Delusions.
3. HALLUCINATIONS. Perceptual problems and hallucinations are described in Perceptual Processes/Hallucinations.
4. MOOD. Mood is usually a longer-lasting emotional state, while affect is the instantaneous emotional "feel" or "coloring" of what is expressed. Be sure to differentiate appropriately between mania and hypomania.

I. "Current Health Conditions Placing Client At Special Risk" are health problems of which all providers should be aware, such as a serious heart condition, diabetes, aneurysm, HIV/AIDS, cancer, etc.

J. "Client Strengths" should be personal strengths, abilities, etc., (e.g., highly motivated to improve) rather than circumstantial or environmental advantages (e.g., has SSI, can always turn to mother when in trouble).

K. DYSFUNCTION: Explain clearly in this section the daily functioning dysfunction that justifies services for the client.

L. "Formulation/Explanation of Problems" is an optional area, which may be used to summarize the assessment data and/or put it in a theoretical context.

M. In "DISPOSITION," document any dispositional actions taken (referral to another clinic or to individual or group therapy, day treatment, medication evaluation, ARMC-BH; mandated reports filed; etc.), and any recommendations and other community referrals given to the client or family.

N. SIGNATURES Each person completing a part of the form will sign at the bottom of the form.

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**Billing**

Both assessment forms stand alone for billing purposes, as long as the top line is completed (date, billing time, location, and service type which is ASSESSMENT). No separate ID note is required, although it is sometimes useful for auditors if a note is entered indicating simply that the Assessment was completed as of the current date. (If a billing time is entered on that ID note, place the time in parentheses, indicating that it is not a separate billing.)

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**Clinical assessment update ("re-intake")**

(As of 9-6-05, the two-page Clinical Assessment Update is no longer used.)

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# Psychiatric Evaluation For Children and For Adults

| | |
|---|---|
| **Psychiatric Evaluation form** | The appropriate Psychiatric Evaluation form (for children or for adults) will be used for the required psychiatric evaluation for all clients receiving medication services. It will be completed before medications are prescribed (except in some exceptional or emergency situations) and will be filed in the chart in the back section under the Evaluation/Admission tab. |
| **Completing the form** | (See 2-3.1 for general instructions for all assessments.) Every blank must be completed, if only with N/A or N/Av (not available). |
| **Diagnostic Impression** | Note that the official diagnosis for the client is the one written on the blue Diagnosis form. All staff involved in diagnosing a client should meet to resolve differences in diagnostic impression. |
| **Management** | Note that recommendations in "Management" must be communicated through appropriate channels to other staff if they are to be involved in the care of the client. |
| **Billing** | The form stands alone for billing and does not require an accompanying ID note. |

# Client Recovery Evaluation

**Purpose**

The **Client Recovery Evaluation (CRE)** provides for a structured assessment of client community and other functioning and is one method of clearly documenting medical necessity and need for services.

**Form used as tool**

The **CRE** is **not required** but is a useful tool to:

- Document medical necessity
- Assess a client's needs for service planning

**Form completion**

In completing the **CRE** describe the:

- Client
- Client's functioning
- Client's situation in such a way that makes clear the need for services
- Client's problems and strengths

**Note:** Give examples wherever possible.

**Substance problems**

If substance problems are described, consider whether an additional substance-related diagnosis should be added to the client's diagnosis

**Client Functioning and Symptomatology**

The focus of the form is largely on functioning, but the section for **"Significant Symptomatology"** should be used to include significant symptoms, such as:

- Mood problems
- Dissociative problems
- Psychotic features

**Client progress**

In **"Progress with Recovery and Goals",** describe the client's progress over the past year.

**Client impairments**

In **"Impairment…"** tell why the client needs services and describe the dysfunction that justifies payment for those services

*Continued on next page*

# Client Recovery Evaluation, Continued

**Signatures**

The form may be completed and signed by any clinical staff, including:

- Mental Health Specialists
- Social Worker II's

See **Co-Signatures** section for co-signature instructions.

# Client Recovery Plan

**Purpose**

The **Client Recovery Plan** covers the following areas:

- Specifies the goals for treatment
- Describes services to be provided to the client
- Provides documentation of client participation in treatment planning
- Serves as a vehicle for review of certain services

**Required completion**

It is required to have **Client Recovery Plans** for:

- AB 2726
- CARS
- CalWORKs
- Crossroads/Laurelbrook
- Court-ordered domestic violence and anger–management cases

**Important Note:** These cases will be subject to review

**Exceptions**

It is not required to have **Client Recovery Plans** for:

- IMD clients
- State hospital clients
- Non-Medi-Cal CONREP clients

**Services included in the plan**

The following guidelines apply to services provided to the client under the **Client Recovery Plan**:

- All services (except TBS) must have plans using the client's **Client Recovery Plan**
- Only services that are provided at a given site will be included on that site's **Client Recovery Plan**
- Separate **Client Recovery Plan** pages may be used for separate services, if desired
- Occasional, unplanned services do not require a **Client Recovery Plan**
- The following chart applies to clients who transfer to other DBH sites:

| If a … | And… | Then… |
|---|---|---|
| Client transfers to another site | There is still authorized time on the **Client Recovery Plan**, | The new site may continue to provide services according to the old **Client Recovery Plan** until its expiration. |

*Continued on next page*

**Timelines**

The following timelines/requirements apply when completing the **Client Recovery Plan**:

- Upon initial entry for services, SIMON will give an **automatic two-month authorization for services**

| If… | Then… |
|---|---|
| Services are to continue past the initial two-month intake period, | The **Client Recovery Plan** will be completed within two months of entry. |
| **Example**: Entry on May 17 would require a **Client Recovery Plan** no later than July 16. | |

- Following this initial two-month period, any added service will result in a **Client Recovery Plan** being completed for that service within one month of the start of that added service ***if*** the service is to be continued beyond that one-month period
  - Services in the 30-day period will be disallowed if the **Client Recovery Plan** is not completed within the 30 days, since the effective date of the **Client Recovery Plan** is the date of the signature if not completed within a defined window period.
- ***Best Practice:*** *Good clinical practice includes completion of assessment and client planning as soon as possible, so clinicians are urged to complete plans as soon s possible*

**The Client Recovery Plan for each service must be re-written every 12 months.**

**Coordination of services at multiple sites**

The process for co-ordination of services at multiple sites is as follows:

| Step | Who Completes | Action |
|---|---|---|
| 1 | Clinic staff | Before opening a service episode or adding a service, check SIMON for existing services for that client. (This will prevent duplication of services). |
| 2 | Supervisor or Team | • Call ***all*** sites providing services<br>• Discuss the advisability of starting or adding proposed services<br>– This ***must*** be done if other sites are providing **ANY TYPE** of other services).<br>• Staff need not be in agreement about adding the service, but must discuss the matter |
| 4 | Supervisor or Team | Chart this coordination effort (including the reason for opening the new service, if the other sites do not recommend doing that). |

*Continued on next page*

**Clients who will receive team oversight**

The following criteria applies to those clients who may be considered appropriate for team rather than non-team oversight:

- At any point in the care sequence (but usually during screening), a client may be identified as a client for whom a team should take responsibility
- Non-team clients will not become the responsibility of a team and will be overseen by clinic supervisory staff, in accordance with written Department criteria for team versus non-team clients

The following chart delineates "Team" from "Non-Team" clients:

| Team | Non-Team |
|---|---|
| Clients who have serious disruption of daily community functioning due to mental disorder. | Cases that are "simpler" and can be appropriately managed by a single provider |
| Cases of sufficient complexity or severity that the joint care planning of a team or the joint services of various team members is needed if the client is to be properly served. | |
| Clients receiving DTI or DTR services. | |

**Billing without authorization**

It is the intent of the Department that all care will:

- Have appropriate oversight
- Be carried out with benefit of a **Client Recovery Plan**
  - That there will be no periods of care for which there is no operative **Client Recovery Plan,** with the exception of the intake period if services do not go beyond that intake point

The feature of SIMON that will not bill a service unless an authorization is on file in SIMON for that service has been ***turned off.*** This actions was taken because it is believed that:

- Local oversight by supervisors and teams is sufficient to ensure that almost all services are appropriately authorized
- Current blockage of billing due to entry errors - where a service is in fact properly authorized in the chart but not in SIMON - are greater than any recoupment by third-party payors that could occur for services that are billed but turn out not to have been properly authorized

**Completing the Plan (time)**

It is estimated that the **Client Recovery Plan** will require approximately two minutes per service type (six minutes total per modality including discussing goals with a client.

*Continued on next page*

# Client Recovery Plan, Continued

**Who completes the CRP?**

The following staff completes the **Client Recovery Plan**:

- Clinic staff or the team will complete the **Client Recovery Plan**
- Staff or the team may subsequently prepare new **Client Recovery Plans** for their services
- Several staff members may enter information on the **Client Recovery Plan**
- Persons signing the **Client Recovery Plan** as '"STAFF" must be clinic staff members who are qualified to provide that service, and may include the service Team leader
- An M.D. must sign for MSS services, however:
  - Another staff member may check the box at the top indicating that MSS services are being for will be provided.

**Client's goals and desired outcomes**

The following are guidelines for completion of the Goals and Desired Outcomes section of the **Client Recovery Plan:**

- Goals and desired outcomes should be negotiated with the client until goals are formulated that the client wants and that legitimately require DBH services
- Using the client's own words is desirable in this section
- In some cases there will be a single goal for a given episode of treatment
- In complex cases, more than one goal may be appropriate
  - ID notes describing treatment must illustrate work on the listed goals and not on other areas
- The client's own goals for services should have priority, as long as they:
  - Are related to community functioning
  - Require DBH services for their achievement

*Continued on next page*

**Behavioral, Measurable, Relevant Objectives, Related to Community functioning**

The following criteria apply to charting behavioral, measurable and relevant objectives:

Enter specific, measurable, behavioral criteria that are:

- Relevant to the client's community functioning goals
- Indicate when the final goal is reached or when specific steps in the process of reaching that final goal will end

The following chart shows examples of treatment goals and behavioral, measurable and relevant objectives.

| Treatment Goal | Objective |
|---|---|
| Prevent suicide attempt | • No suicide attempts or gestures for 4/1/06 through 6/30/06, as reported by client<br>**OR**<br>• Client will state she does not wish to die can cite 3 reasons to live by 5/31/06, as reported by client |
| Develop social support system and the skills to maintain it | Will make three friends and have contact with each of them at least once week for the month of June 2006, as reported by client |

**Objective specifics**

Objectives must:

- Be time-framed in terms of when:
  - They are expected to be accomplished
  - It will be measured as to whether or not they have been accomplished
  - An actual date or dates, such as 4/1/06 must be entered
- Include a method of measurement, which could be stated in any of the following ways:
  - "By client report"
  - "As indicated in the chart"
  - "By parent report
- Operate within the Medi-Cal Rehabilitation Option
  - Requires that objectives be related to the client's community functioning, rather than to changes in symptoms or subjective state
- Be relevant
  - Clearly and reasonably connected to the client's presenting issues, central complaint, or areas of dysfunction
- Be relevant (as defined above) and related to the client's community functioning
- Be measurable
  - The provider's judgment or opinion regarding reaching the treatment goal or readiness to terminate treatment cannot substitute for an observable criterion. Since they are measurable, the objectives could theoretically be assessed by an outside observer based on the objective's language

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**Other considerations**

Other things to consider when developing an objective are:

- One treatment modality and objective are sufficient for a treatment episode
- One objective may be sufficient:
  - Even if there are multiple goals, depending on the client's readiness to change
  - For several modalities
- Clients should participate in determining the objectives, so that they will know how to take greatest advantage of the services available, and clients will normally be given a copy of their **Client Recovery Plan**
- The amount of services available to any one client will depend on:
  - Client need
  - Resources available at that time, as determined by the Department, the supervisor, or the team
- The following chart applies to when a client reaches their goal or maximum benefit:

| If… | Then… |
|---|---|
| Objectives are reached before:<br>• Goal dates, or<br>• End of the authorization period | Treatment will stop at that point unless new objectives are written in the **Client Recovery Plan** |
| Client has reached maximum benefit from treatment, regardless of whether the end of the authorization period has been reached. | |

**Dysfunction rating and behavioral evidence**

The dysfunction rating is made using the dysfunction rating tables. Behavioral evidence justifying the rating must be entered on the **Client Recovery Plan.**

**Individual's actions**

This section is no longer required.

*Continued on next page*

**Staff actions**

Use the following steps when completing the Staff Actions section of the **Client Recovery Plan:**

| Step | Section | Action |
|---|---|---|
| 1 | Type of Treatment | Enter each type of treatment to be provided in a separate numbered **Client Recovery Plan** section. Enter the sub-type as well<br>• MHS – ind. ther.<br>• MHS – ind. and group ther.<br>• CM – L&C<br>Use the abbreviations specified in the **General Instructions for All Interdisciplinary Notes** section of this handbook.<br><br>More than one type of MHS service may be placed in one section of the **Client Recovery Plan**, if they have the same foci of treatment, but the frequencies of each must be specified separately. |
| 2 | Enter the frequency of client/provider contact for each proposed modality (once/wk., etc.). | • If more than one service in a modality is planned, clearly list the frequency for each. "PRN" (as needed) service is only appropriate for occasional, ancillary services and not for a planned, primary service<br>• For services in which unpredictable variation is expected, enter the expected frequency along with PRN (e.g., "once a month and PRN". The focus of treatment should relate clearly to accomplishing the treatment goal<br>• For most cases one or two modalities of treatment will be sufficient |
| 3 | Focus of treatment | Enter the focus of the treatment, which is what the provider will focus on or work on in treatment that will help the client to make progress toward the objectives and goals (e.g., "anger management," or "deep fears of trusting other," or "decrease anxiety") |

*Continued on next page*

**Staff actions** (continued)

<table>
<tr><td>4</td><td>Expected end date (duration of treatment) considerations:</td><td>• Providers are expected to make services efficient (i.e. to reach client goals as soon as possible)<br>• With some exceptions, treatment of non-team clients should be planned from the beginning with an aim toward termination before the end of the first services period.<br>– It is recommended that a termination date be set with these clients, so that both provider and client gauge their work within this time frame.<br>– Clients are informed of this expected termination date and are involved in keeping track of progress and of what remains to be done in the remaining time.</td></tr>
<tr><td>5</td><td>Amenability for treatments proposed:</td><td>• The client must have the cognitive and emotional abilities to be able to participate actively in the proposed treatment and must be motivated to participate sufficiently to reach significant benefit<br>• All three boxes must be checked if a service is to be provided</td></tr>
<tr><td>6</td><td>SPAT Exemptions and Extensions</td><td>Use the following table to determine who grants and signs SPAT exemptions and extensions:</td></tr>
<tr><td></td><td colspan="2"><table><tr><th>If…</th><th>Then the following person will check the appropriate box and sign…</th></tr><tr><td>A Program Manager grants an exemption</td><td>Program Manager</td></tr><tr><td>A Clinic Supervisor granting an extension</td><td>Clinic Supervisor</td></tr></table></td></tr>
</table>

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**Staff actions** (continued)

| | | |
|---|---|---|
| 7 | Signatures | The following requirements apply to staff signature on the **Client Recovery Plan**. Every:<br><br>• Staff member who enters part of the **Client Recovery Plan** will sign the **Client Recovery Plan**<br>• Time a staff member signs the Plan, he/she affirms that the client participated in developing the Plan |
| 8 | Client involvement and signature. | • The client is to be involved in determining the treatment goals and objectives, so that he/she can participate most effectively in the treatment effort<br>• The client's signature will be obtained on every plan, including the initial **Client Recovery Plan**<br>• Clients will normally be given a copy of their **Client Recovery Plan** (with notation of the date it is given in the bottom right corner of the **Client Recovery Plan**)<br>• ***Best Practice:*** It is good clinical practice for parents/guardians of minor clients to be informed about the plan of care and to sign the **Client Recovery Plan**, but if this is not feasible then the signature of the minor child is acceptable |
| | **If the client…** | **Then…** |
| | Refuses to sign the **Client Recovery Plan**, | Renegotiate the goal. |
| | Agrees with the goal, and the treatment proposed but still refuses to sign the **Client Recovery Plan**, | Note that fact in the signature space and obtain the client's signature as soon as it is possible to do so. |
| | Does not agree with the treatment goal or treatment methods, | Consult with he supervisor or team regarding whether treatment should be provided (except for crisis services) |

*Continued on next page*

**Staff actions** (continued)

| | | |
|---|---|---|
| 9 | Effective Period for the **Client Recovery Plan**: | When entering the effective date of the **Client Recovery Plan**, the following rules shall be followed:<br>• The services period for all services may be up to 12 months long<br>• All planned services are authorized for the same time period (with the exception of services controlled by the SPAT authorization system)<br>• The initial date (effective date) of the **Client Recovery Plan** is the:<br>– Start of the defined window period (initial 60 days, or 30 days for a new service) if the **Client Recovery Plan** is completed in that window period, or<br>• Date of signature of the **Client Recovery Plan** if completed at any other time. The ending date of a period is entered after "end date"<br>• Each **Client Recovery Plan** will be rewritten on a new form<br><br>**Note:** Out-of County Medi-Cal cases will follow the authorization periods given by those other counties. |
| 10 | Spat Period | The beginning and end dates of the SPAT period will be entered here for services covered by SPAT |
| 11 | Variation if MSS-Only | If the client is to receive MSS services only, the Client Goals section may be omitted. No client signatures or review signatures are a required for MSS-only cases (since clients will be signing the meds consent form for each new medication.) |

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# Client Recovery Plan, Continued

**Changing the Plan**

During any services period, providers, supervisors and teams may alter the **Client Recovery Plan**.

- Providers altering a **Client Recovery Plan** need not get approval for the change but must:
  - Document the planned services change in the **Client Recovery Plan**, and
  - Explain the change in an ID note.
- A current **Client Recovery Plan** may be amended to reflect a reduction in the current services period without a re-write of the **Client Recovery Plan**
- Changes are noted on the current **Client Recovery Plan** by:
  - Adding new information and crossing out deleted information, with date and provider initials and signature below
  - Chart note on that same date explaining the change
- A service added during a current authorization period will expire at the end of that authorization period

**Location in chart**

- All **Client Recovery Plans** will be filed together in the chart at the top of the front left section of the chart, with current services on top, so that providers may check expiration dates easily before each service.
- **Client Recovery Plans** will be filed on top of the Diagnosis sheet, which will be filed on top of the Care Necessity form.
- Providers are urged to review the **Client Recovery Plan** at every client session, for goals and expiration dates.

**Termination period**

If it is directed that services be terminated, a one-month period will be allowed for appropriate client termination.

# Medication Support Services (MSS) Service Plan (Client Plan)

**Included documents**

The MSS service plan includes the following documents:

- Client Recovery Plan
- MSS ID notes
- Medication Consent form
- Outpatient Medication Record

**Document specifics**

Specific information on the service plan documents is included below:

| Document Name | Purpose |
|---|---|
| Client Recovery Plan | • A plan for all ongoing, planned MSS services must be documented using the Client Recovery Plan form.<br>• Any staff may check the box indicating that medications are being provided.<br>• Physicians only may fill in the "modality" line for MSS, indicating the frequency and expected duration of the service and sign the form. |
| Medication Consent Form | • In the Medications Consent form, documentation of the following information are essential aspects of his/her medications:<br>– Information provided to the client and<br>– The client's indication of participation in the planning for his/her medications<br>• Clients must sign for every change in medication. |
| Outpatient Medication Record | • The Outpatient Medication Record (or "Meds Order sheet") documents the medications actually provided and the client's ability to participate appropriately in his/her medication planning. |
| MSS ID Notes | • The MSS ID notes may contain documentation of any of the above plan items and are therefore viewed as part of the MSS plan. |

**Authorization**

It is not currently required that Medication Support Services be authorized

**Documentation for MSS Cases**

SEE Schedule of Chart Form Due Dates section regarding charting and forms requirements for Medication Cases.

# Out-of-County Authorization Form

**Overview**

The Department's out-of-county authorization form will be used in all charts that are funded by out-of-county Medi-Cal. The following information outlines procedures for initial services and extension of services.

**Initial services**

New clients with out-of-county Medi-Cal are directed to call their county's access unit for initial approval (usually of a few evaluation visits), or the DBH Access Unit will call the other county. The Access Unit will initiate the out-of-county authorization form (OOCA) and, when the other county's initial authorization is received, the Access Unit will send the OOCA to the clinic as the documentation of the other county's initial authorization. It will be filed in the chart (see filing instructions below).

**Extension of services**

After the initially authorized evaluation visit or other visits, in order to request further authorization, the provider will complete the initial DBH forms (Clinical Assessment, Client Plan, Care Necessity form, Diagnosis sheet) and send them to the Access Unit along with the OOCA. The Access Unit will forward them to the other county, and when the authorization is returned, the Access Unit will forward that and the updated OOCA to the clinic, which will file it in the chart.

**Note:** Whenever further out-of-county extensions are needed, the clinic will send to the Access Unit an OOCA along with either the existing Client Plan, Care Necessity form, and Diagnosis sheet, or an updated Client Plan, Care Necessity form, and Diagnosis sheet (see 'the controlling authorization if there are differences' below).

**The controlling authorization if there are differences**

If the out-of-county authorization and the DBH authorization differ, services will be delivered to the client according to the DBH authorization. The DBH re-authorizations will proceed according to DBH procedures and schedule. Clinics will ensure that out-of-county authorization expirations are monitored separately from DBH authorizations. (A card-file tickler system for all of a clinic's out-of-county clients, that was checked weekly, could be sufficient.) Clinicians will check the out-of-county authorization frequently and will submit re-authorization requests at least three weeks before the out-of-county authorization expires. If the out-of-county authorization expires before the DBH authorization, the existing DBH paperwork (Client Plan, etc.) will be submitted with the OOCA at that time, rather than preparing new DBH paperwork early.

**Filing**

The OOCA will be filed in the chart in the front left section, on top of the "blues."

# Review/Authorization System for Psychotherapy and Rehab/ADL: SPAT

**SPAT Rationale**

A system of allowable treatment periods is necessary to:

- Ensure that all clients who could benefit from psychotherapy or rehab/ADL services can receive them
- Promote efficiency of treatment and maximum participation by both providers and clients
  - (Other services, such as meds and case management are not limited by SPAT at this time)
  - The SPAT periods apply to both individual and group psychotherapy and individual and group rehab/ADL

**Why is SPAT necessary?**

Psychotherapy and rehab/ADL counseling are scarce resources, and must be:

- Used for specific purposes
- Defined in advance for a given client, rather than as “treatment as usual” for “whatever ails you”

**How are SPAT limits set?**

The allowed periods (numbers of months) are chosen to equalize the number of clients beginning a SPAT period and the number ending one.

- As staff resources change, the SPAT limits may be increased or decreased
- These treatment periods have also been set at levels that are adequate to permit significant treatment gains, if client and therapist are using all available sessions actively and competently in the pursuit of change goals

**How are allowable treatment periods determined?**

Allowable treatment periods are determined by:

- The client’s diagnoses, including severity
- The client’s rated dysfunction
- Whether the client meets Medi-Cal medical necessity rules
- The clients motivation and amenability to various forms of treatment (whether the client has the emotional and cognitive skills and abilities to benefit form various forms of treatment)
- The client’s desired forms of treatment

A proposed treatment regimen is developed and the length of treatment is read from the table.

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**SPAT dates and coverage**

The following are general considerations:

- SPAT dates are recorded at the bottom of the Client Recovery Plan
- Individual providers, teams or Clinic Supervisors may reduce SPAT periods of treatment. (The SPAT period of treatment is a maximum period and not an entitlement.)

Use the table below to determine the correct process in specific situations:

| If… | Then … |
|---|---|
| This is a new case | The SPAT start date is the DOE, and the end date is at the end of the number of months allowed by the SPAT table. |
| This is a newly added service | The SPAT start date is the start of the 30-day window available for completion of the Client Recovery Plan. |
| There are multiple diagnoses and multiple problems | One diagnosis only is chosen for psychosocial treatments in any given SPAT episode. |
| Both psychotherapy and rehab/ADL are provided | One SPAT period covers both services |

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**Application to already open cases**

With the start date of the new system (4.4.05):

- Every chart should be checked upon the next visit to determine if psychotherapy or rehab/ADL services are being provided
- A dysfunction rating should also be made, using the new rating system and recorded on the current Client Recovery Plan

| If… | And if the… | Then … |
|---|---|---|
| Psychotherapy or rehab/ADL services are being provided, and | Dysfunction rating is 0 or 1, | A one-month termination period will be instituted for those services. |
| Psychotherapy or rehab/ADL services are being provided, and | Dysfunction rating is 2 or 3, | A new allowable time period will be applied to the case, beginning with the start time when the psychotherapy or rehab/ADL was begun on the most recent **Client Recovery Plan** (during the past year in most cases). |

| If this allowable time period expires … | Then the modality duration for psychotherapy and rehab/ADL will be … |
|---|---|
| More than 5 months into the future (from the date of checking), | Changed to new SPAT expiration. |
| Less than 5 months from the date of checking, | Set to 5 months from the date of checking |

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**Example**

Psychotherapy has been provided since 2/1/05 in a case with a diagnosis of Depressive Disorder NOS. A Client Recovery Plan allows services for a period of 2/1/05 through 1/31/06. The new system is implemented 8/15/05

| If… | Then… |
|---|---|
| The dysfunction level is 3, | The table shows a maximum 9 month treatment period for the psychotherapy, which would expire 10/31/05. Since the expiration of 10/31/05 is less than 5 months in the future, the duration for the psychotherapy on the Client Recovery Plan was changed to 1/14/06 (5 months from 8/15/05). |
| The dysfunction level had been 2 , | The table shows an allowable treatment period of 6 months. The six month allowable treatment period would have expired 7/31/05. Since that has already past, five more months of psychotherapy would be allowed from 8/15/05 (to 1/14/06). |
| The current Client Recovery Plan was 2/1/05 through 1/31/05, the SPAT allowed period was 9 months (from 2/1/05), and the chart was checked for this on 4/15/05, | The Client Recovery Plan end date would be re-set to 10/31/05 |
| The diagnosis was Reactive Attachment disorder with dysfunction level 3 (allowable treatment period 12 months and current Client Recovery Plan duration for the psychotherapy 2/1/05 through 1/31/05) | There would be no change in the psychotherapy duration on the Client Recovery Plan. |
| The dysfunction level had been 2 (allowable treatment period 9 months) | The allowable treatment period would expire 10/31/05.Since that was less than 5 months in the future from 8/15/05, the psychotherapy end date on the Client Recovery Plan would be set to 1/14/06 (5 months from 8/15/05) |

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**Careful and accurate interpretation of Medi-Cal Medical Necessity**

In order to use available resources appropriately (for the clients for whom they were intended), it is essential to ensure that client:

- Conditions and dysfunctions meet Medi-Cal medical necessity criteria for "significant impairment in an important area of life function."
- Impairments must make achieving acceptable levels of normal living and functioning unattainable without treatment, in areas of:
  - Self-responsibility
  - Earning a living
  - Carrying out planned and routine daily activities
  - Education toward appropriate adult functioning
  - Maintenance of minimal social contacts

**Notes:**

- Category one (mild) dysfunction ratings generally do not meet medical necessity (except for EPSDT clients)
- Clinic Supervisors and auditors will be reviewing these ratings for supporting evidence to ensure that appropriate judgments are being made

**Active treatment**

All staff-provided treatment must be aimed clearly at client change, with the exception of:

- Maintenance medication when psychosocial treatments have proven to be ineffective
- Monitoring and case management for cases specifically identified as requiring indefinite services due to recurrent client needs

Other considerations for treatment include:

- Clients must be able, very near to the start of treatment, to participate actively and productively
- Maximum advantage must be taken of allowable treatment periods
- Sessions must be focused by the clinician on the next step in moving toward change
- Psychotherapy cannot be used only to provide support, which can be provided in rehab/ADL counseling, in case management, or in other ways

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**Approach to care**

In addition to requiring an active stance in treatment by clinicians, this approach to care requires that clinicians:

- Think more carefully in advance about what clients can accomplish and the methods of treatment that can work for them
- Maximize benefits to clients by planning out the whole period of treatment in terms of a sequence of necessary foci
- Structure sessions to ensure the greatest benefits by clients in the sessions allotted
  - If providers are unsure how to maximize treatment benefit for a client, they will be provided consultation assistance

**Amenability for treatment**

The following policies apply when reviewing the client's amenability for treatment

- Clients will not be given treatment if they are not motivated to work to attain the goals specified
- A brief opportunity will be afforded to initially resistant clients to form a treatment alliance and to become willing to change, but if this brief effort fails, the treatment should generally be stopped
- Clients will not be given treatments that they are not motivated to participate in or that they do not have the emotional and cognitive capacities to participate in
- Amenability criteria that have been provided should be consulted, and if the client cannot participate appropriately, other types of treatment may be considered

**Client participation**

Clients will be:

- Expected to attend all scheduled appointments
- Informed of the treatment periods at the beginning of the treatment

As to specific aspects of client's non-participation, use the following table:

| If Client… | Then… |
|---|---|
| Shows non-attendance sufficient to render current treatments ineffective | Those treatments will be terminated |
| Is not exerting effort in the treatment, to:<br>• Disclose,<br>• Do homework, etc | |
| Proves not to have the intellectual capacity to participate effectively in the treatment, | That treatment will be terminated |

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**When to stop treatment**

Treatments should be terminated for clients who:

- Have reached maximum benefit from a treatment
- Have reached treatment goals before the end of a SPAT period
- Are discovered not to have sufficient motivation or capacities for a given treatment

**Separation between episodes**

The separation between episodes of psychotherapy or rehab/ADL will normally be at least six months.

If a previous dysfunction level 3 problem recurs, a new episode of psychotherapy and/or rehab/ADL may be begun, unless past treatment for this dysfunction was not effective, in which case a new treatment episode may be begun only if there is reason to believe that this treatment will be more effective

If newly developed or recurrent dysfunction level 2 problems occur during the six-month hiatus (suicidal ideation, second suspension/expulsion in last year, significantly increased fighting etc.) a one month period of services is allowable, including psychotherapy and rehab/ADL.

| If… | Then… |
|---|---|
| • Newly developed dysfunction level 3 problems occur during this six-month period, or<br>• Due to mental disorder any child:<br>– Is expelled from school,<br>– Makes a suicide attempt,<br>– Seriously harms another person, or<br>– Is under a serious threat of out-of-home placement during this period, | A new episode of psychotherapy and/or rehab/ADL may be begun immediately with a new SPAT period (without approval, as long as the new problems are documented well.) |

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**Application to AB2726 cases**

SPAT applies to AB2726 cases but at the end of the first SPAT period, use the following table to determine if another SPAT period is appropriate:

| If… | Then… |
|---|---|
| • The client is amenable to the treatment and is making clear progress, or<br>• An appropriate type or frequency of treatment has not yet been tried. | The Clinic Supervisor may approve continued psychotherapy and/or rehab/ADL in an AB2726 case for another SPAT period of the same length.<br><br>**Note**: This renewal may be done any number of times as long as one of these criteria is met. |

| If… | Then… |
|---|---|
| approval is not given, | the clinician should seek agreement at an IEP meeting (or by mail) that services be discontinued for the time being |

**Re-computation of SPAT Period**

Use the following table to determine when to re-compute the SPAT period:

| If... | And if... | Then… |
|---|---|---|
| The diagnosis is changed during a SPAT period | The Clinic Supervisor approved based on the new diagnosis | A new SPAT period may be started at that point and entered in SIMON |
| The rated dysfunction level changes from level 2 to level 3 during a SPAT period, | The Clinic Supervisor approves based on the new dysfunction level | A new SPAT period may be started at that point and entered in SIMON |

*Continued on next page*

**Exceptions via Treatment Authorization Requests**

The following policy applies to exceptions:

- Allowable treatment periods for psychotherapy and rehab/ADL will be adhered to
- There will be no extensions of these limits, except as described below.
  - Additional sessions at the end of a period of Psychotherapy or rehab/ADL for target disorders (for up to a maximum of 3 additional months) may be requested from the Clinic Supervisor via the TAR form
- Justified means being of significant benefit to the client of completing therapeutic work currently active and already in progress, and not by the desire to raise new issues or to do "more". The following are examples of inadequate or vague justifications for additional sessions:
  - "Just about to make a breakthrough"
  - "Would be harmed by termination"
  - "Need more time"
  - "now ready to work in therapy"
- Additional sessions for non-target disorders (levels 2 and 3) may be requested from the Access Unit via a TAR (accompanied by copies of the Clinical Assessment, Diagnosis page and Client Recover Plan), for an additional 3 months (or less) (level 2) and 6 months (or less) (level 3)

| If... | Then... |
|---|---|
| A TAR extension is granted | Change the modality end date in the Client Recovery Plan (and in SIMON) to the new end date. |

| If that change... | Then... |
|---|---|
| Takes the modality end date beyond the Client Recovery Plan end-date, | The plan end may be extended date to correspond |

| However If that change... | Then... |
|---|---|
| Takes the modality end date beyond the Client Recovery Plan end-date, | The client Recovery plan must still be rewritten at least annually. |

*Continued on next page*

# Review/Authorization System for Psychotherapy and Rehab/ADL: SPAT, Continued

**System-Initiated Monitoring and Treatment**

The MHP may:

- Identify certain clients for their high use of crisis or hospital services or their frequent harm to self or others
- May assign staff to provide services to these individuals outside of the usual practice or authorization guidelines

These exceptions will be:

- Authorized by the Program Manager at the request of the Clinic Supervisor
- Recorded o the Client Recovery Plan

**Note:** All Client Recovery Plans must be re-written at lease annually.

**Program Exemptions**

Certain programs will be exempt from the SPAT lengths of care but will still follow the practice guidelines including the forensic programs. Programs must receive these exemptions from their Program Managers.

**Teams**

Clinics/programs may wish to have teams make treatment planning decisions regarding services to be provided and treatment approaches to be used. The following persons or groups of persons may reduce the SPAT periods of treatment:

- Individual providers
- Teams
- Clinic Supervisors

***Remember:*** The SPAT period of treatment is a maximum period and not an entitlement.)

**SIMON entry**

SPAT start and end dates will be entered SIMON, after they are recorded on the Client Recovery Plan by clinicians.

**MHS863 Report**

The following reports are issues to warn of impending points and dates:

- The MHS863 report will continue to warn of impending annual points
- The MHS 864 report will warn of intake period end dates and SPAT end dates

**However**, providers are advised to check in the chart at each visit, to ensure appropriate planning of the remaining course of treatment. All clinics must be sure to receive the 863 and 864 reports; contact Computer Services if these reports are not being received.

# Services Team Actions Form

**Completion of form**

All services team actions regarding the client's care will be documented using this form, including:

- Assignment of providers
- Authorization of services (if required)
- Non-authorization of services
- Team-directed changes in the services provided or the approach used in providing those services
  - Team discussions regarding a client's care that do not result in a team action may be documented either on this form or in an interdisciplinary note.
- It is intended that this form will assist teams in considering whether services are necessary and will help them to document justifications for granting or for not granting authorizations
  - Teams may make decisions about a case that alter the nature of services but which have nothing to do with "authorization,"

| If... | Then... |
|---|---|
| There is no required authorization program that applies to those services | Do not check boxes that refer to "authorization". |

**Placement**

The form is placed in chronological sequence among the other ID notes in the chart.

**Billing**

Billing information is entered at the top of the form. No additional ID note is required for billing. (See Billing section for procedures for billing by each team member participating of by one team member for all who participate)

**Staff and other present**

Complete the "Staff and Others Present" section as follows:

| Step | Action |
|---|---|
| 1 | Check whether the client is present, and enter the names of collateral persons present (family, etc.) and of team members present. |
| 2 | Circle the names of those staff members who contributed to the discussion for that client and whose time is therefore being billed.<br>• Names of team members may be pre-entered on the form. |
| 3 | If Step 2 is done:<br>• Cross out the names of any not present, and<br>• Circle the names of those for whom billing is being done for that particular client. |

*Continued on next page*

# Services Team Actions Form, Continued

| | |
|---|---|
| **Team deliberations and actions** | Describe in this section any:<br>• Actions taken<br>• Conceptualizations developed<br>• Changes in providers, frequency, etc. of services |
| **Authorization granted or not granted (if applicable)** | The reasons that an authorization is granted or not granted will be explained by checking the appropriate boxes or writing in information. Checking any one box in the section for "...NOT GRANTED..." may be sufficient grounds for not authorizing services. |
| **Team – directed changes in client care** | The team may direct a change in the type of services provided, and this may be documented by checking boxes and filling in blanks appropriately. |
| **Signature** | Any team member may complete and sign the form. (If a multiple billing is done, the team member doing that billing should sign the form.) |

# Spat Exceptions (for working purposes only – not to be filed in client's chart)

**Extensions of SPAT periods**

The following describes examples for SPAT period extensions:

- The client has a target disorder, and the client is in the middle of active work on an important therapeutic issue at the end of the current SPAT period and would benefit significantly from being allowed to finish this work
  - Additional sessions for up to a maximum of 3 additional months may be requested from the clinic Supervisor via the TAR form. If approved, the Clinic Supervisor signs the Client Plan to that effect.
- The client has a non-target disorder and is receiving psychotherapy and/or rehab/ADL
  - Up to an additional 3 months (level 2) or 6 months (level 3) may be requested from the Access Unit via a TAR accompanied by copies of the Clinical Assessment, Diagnosis page and Client Recovery Plan. The approved TAR is filed in the chart with the Client Recovery Plan.

**Exceptions during the 6-month hiatus between SPAT periods**

The following describes exceptions during the 6-month hiatus between SPAT periods.

- Newly developed or recurrent dysfunction level 3 problems have occurred
  - A new SPAT episode may be begun, unless past treatment for a recurrent dysfunction was not effective, in which case a new treatment episode may be begun only if there is reason to believe that the proposed treatment will be more effective.
- Newly developed or recurrent dysfunction level 2 problems have occurred (e.g., in children, suicidal ideation, second suspension/expulsion in last year, significantly increased fighting, etc.)
  - A one-month period of services is allowable, including psychotherapy and rehab/ADL.
- The child has been expelled from school
- The child has made a suicide attempt
- The child has seriously harmed another person
- The child is under a serious threat of out-of-home placement

**Note:** For children in the above four circumstances, a new episode of psychotherapy an/or rehab/ADLmay be begun immediately with a new SPAT period, without approval, as long as the new problems are documented well.

**AB2726 Exception**

Clinic Supervisor agrees, at the end of any SPAT period that the client is amenable to the treament and is making clear progress and /or an appropriate type or frequency of treament has not yet been tried.

**Note:** Psychotherapy and/or rehab/ADL may be continued for another SPAT period of the same length.

*Continued on next page*

## Spat Exceptions (for working purposes only – not to be filed in client's chart), Continued

| | |
|---|---|
| **Diagnosis or dysfunction level changes** | The following describes situations that call for a new SPAT period:<br>• The client's diagnosis was changed during a SPAT period, and the Clinic Supervisor agrees that a new SPAT period should be started based on the new diagnosis<br>• The client's rated dysfunction level changed form level 2 to level 3 during a SPAT period, and the Clinic Supervisor agrees that a new SPAT period should be started based on the level 3 dysfunction |
| **Exceptions based on individual's chronic dysfunction** | A Program Manager agrees that the client has high use of crisis or hospital services and/or frequent harm to self or others and as a result requires ongoing services outside of the usual practice and authorization guidelines. The approving Program Manager will sign the Client Recovery Plan approving this status. |

# Target populations, Authorizations, and Dysfunction Ratings

**Definition**

The DBH target population is defined by the diagnoses and dysfunction levels (2 and 3 only) listed below. Maximum allowable periods of psychotherapy and rehab/ADL treatment are given for each, and for non-target disorders as well. The next two pages contain dysfunction rating examples for adults and children.

**Target Population: SERIOUSLY AND PERSISTENTLY MENTALLY ILL**

Target population is defined by the two groups below:

1. **SERIOUSLY AND PERSISTENTLY MENTALLY ILL**– target population – definition (all from **CHILDREN AT RISK** below, if applicable) plus…
2. **CHILDREN AT RISK**

| Diagnoses | | Maximum Allowed Months | | |
|---|---|---|---|---|
| | Dysfunction Level(s) | 1 | 2 | 3 |
| Anorexia Nervosa (moderate and severe) | 2 and 3 | | 9 | 12 |
| Anxiety Disorder NOS (moderate and severe) | 2 and 3 | | 6 | 8 |
| Bipolar Disorder I and II | 2 and 3 | | 6 | 9 |
| Bipolar Disorder NOS (moderate and severe) | 2 and 3 | | 6 | 9 |
| Borderline Personality Disorder (moderate and severe) | 2 and 3 | | 12 | 12 |
| Bulimia Nervosa (moderate and severe) | 2 and 3 | | 6 | 8 |
| Depressive Disorder NOS (moderate and severe) | 2 and 3 | | 6 | 9 |
| Dissociative Identity Disorder (moderate and severe) | 2 and 3 | | 12 | 12 |
| Factitious Disorder (moderate and severe) | 2 and 3 | | 7 | 9 |
| Generalized Anxiety Disorder (moderate and severe) | 2 and 3 | | 6 | 8 |
| Major Depressive Disorder (moderate and severe) | 2 and 3 | | 6 | 9 |
| Mood Disorder due to a General Medical Condition (moderate and severe) | 2 and 3 | | 6 | 9 |
| Narcissistic Personality Disorder (moderate and severe) | 2 and 3 | | 9 | 12 |

*Continued on next page*

# Target populations, Authorizations, and Dysfunction Ratings,
Continued

**Target Population: Seriously and Persistently Mentally Ill,** Continued

| Diagnoses | | Maximum Allowed Months | | |
|---|---|---|---|---|
| | **Dysfunction Level(s)** | **1** | **2** | **3** |
| Obsessive-Compulsive Disorder (moderate and severe) | 2 and 3 | | 6 | 8 |
| Panic Disorder (moderate and severe) | 2 and 3 | | 5 | 7 |
| Paranoid Personality Disorder (moderate and severe) | 2 and 3 | | 9 | 12 |
| Posttraumatic Stress Disorder (moderate and severe) | 2 and 3 | | 7 | 7 |
| Schizophrenia (and all other diagnoses in Psychotic Disorders) | 1, 2 and 3 | 5 | 6 | 9 |
| Substance – Induced Mood Disorder (moderate and severe) | 2 and 3 | | 6 | 9 |

**Target Population: Children at Risk**

Treatment lengths for children with all target diagnoses are the same. (All applicable from Adult SPMI above) plus:

| | | | Max. Allowed Treatment Months | | |
|---|---|---|---|---|---|
| **Diagnoses** | **But Only …** | **Dysfunction Levels** | **1** | **2** | **3** |
| Attention-Deficit/ Hyperactivity Disorder | If it interferes significantly with appropriate intellectual and social development, which must be justified in charting | 2 and 3 | | 9 | 12 |
| Attention-Deficit/Hyperactivity Disorder NOS | Same as above | 2 and 3 | | 9 | 12 |
| Conduct Disorder | Same as above | 2 and 3 | | 9 | 12 |
| Disruptive Behavior Disorder NOS | Same as above | 2 and 3 | | 9 | 12 |
| Oppositional Defiant Disorder | Same as above | 2 and 3 | | 9 | 12 |

*Continued on next page*

# Target populations, Authorizations, and Dysfunction Ratings,
Continued

**Target Population: Children at Risk,** Continued

| Diagnoses | But Only … | Dysfunction Levels | Max. Allowed Treatment Months | | |
|---|---|---|---|---|---|
| | | | 1 | 2 | 3 |
| Pervasive Developmental Disorders | • Except Autistic Disorder<br>• Those which are amenable to defined specialty mental health services | 2 and 3 | | 9 | 12 |
| Reactive Attachment Disorder | If it interferes significantly with appropriate intellectual and social development, which must be justified in charting | 2 and 3 | | 9 | 12 |
| Separation Anxiety Disorder | Same as above | 2 and 3 | | 9 | 12 |

**EPSDT Cases**

Children at dysfunction level 1 who have a target diagnosis and meet the EPSDT medical necessity requirements may receive 6 months of psychotherapy and/or rehab/ADL

**Dysfunction levels "1" and "0"**

Target disorders listed above with a Dysfunction Level of "1" or "0" (except EPSDT and psychotic disorders) will not receives services including medications.

**Non-Target disorders**

Non-target disorders, those that do not meet above definition of target disorders, may only receive the following maximum allowable treatment months:

| Dysfunction Level(s) | Maximum Allowable Treatment Months |
|---|---|
| 2 and 3 | 3 |
| 1 or 0 | No services |

# Day Treatment Intensive ID Notes

**General instructions**

See "General Instructions for All Interdisciplinary Notes" section for general instructions applying to all ID notes.

**Requirement**

The following notes are required:

- Brief daily ID notes
- Weekly summary of treatment

Other treatment notes may be entered as desired.

**Form completion procedure**

The following table instructs the user in completion of the Day Treatment Intensive ID notes form.

| Step | Section | Action |
|---|---|---|
| 1 | General | The daily notes will be entered on the pink ID note form specifically designed for intensive day treatment only |
| 2 | Day Treatment Intensive-Daily/Weekly ID Notes | At the top of the form, enter the week and locations. |
| 3 | Status Matrix | • Enter for each day the client's condition or status as observed.<br>• This should provide justification for further treatment, if further treatment is needed.<br>• Additional symptoms/problems may be added in the blank lines. |

*Continued on next page*

# Day Treatment Intensive ID Notes, Continued

**Form completion procedure** (continued)

| Step | Section | Action |
|---|---|---|
| 4 | Program Matrix | • Enter all planned and available therapeutic activities for the week.<br>• Write in after the headings provided any further specification of the type of group or treatment (such as "AMAC group").<br>• Add other groups and activities in the blank lines at the bottom.<br>• After this section is filled in, the form may be copied for staff use for that week.<br>• After each activity, write the expected or typical length of the activity (1 hr., 1.5 hrs., etc.<br>• Under each day of the week, place a check mark in the box of each activity in which the client participated.<br>• The location of the service may be noted in the box for each service performed outside the clinic.<br>• Significant absences or partial participation should be explained in the ID notes. |
| 5 | Daily Interdisciplinary Notes | • In the "Daily Interdisciplinary Notes" portion of the form, write a brief, one to three sentence note for each day the client attended that week, commenting on the client's condition and the client's participation.<br>• Date each note in the left column.<br>• No heading is needed on the daily notes.<br>• An example might be:<br>– "1/12/06 John was distracted by voices telling him to harm self today but responded well to work on this in therapy group. Participated well in recreation group aimed at decreasing his severe depression."<br>• If more space is needed for one week of daily notes than is available on one page, continue on the second page of the structured form. |

*Continued on next page*

**Form completion procedure** (continued)

| | | |
|---|---|---|
| 6 | Weekly Summary Notes | • In the portion of the structured DTI ID note headed "Weekly Summary," write the weekly summary note.<br>• ID note content is basically the same as for NHS ID notes, but the note must be more extensive and specific enough to justify the intensive service.<br>• Every note should contain:<br>– A description of the clients current condition and problem being addressed,<br>– The staff's various interventions throughout the week,<br>– The client's responses to the interventions,<br>– The client's treatment –related efforts between sessions if, applicable,<br>– The connection between the treatment provided and the measurable objectives of the client,<br>– Enough indication of medical necessity to justify further treatment, if that is indicated.<br>• Notes need not describe every intervention or meaningful therapeutic interaction for the week, but auditors will expect more than just one, and they will expect specifics rather than generalities.<br>– The description of several interventions and client responses in different activities will probably be sufficient.<br>• Day treatment staff who have treated a given client should share their information with the person writing the weekly summary note before the note is written each week. |

*Continued on next page*

**Form completion procedure** (continued)

| | | |
|---|---|---|
| 6 con't | Weekly Summary Note (continued) | • The weekly summary note must be written by (or reviewed and co-signed by) and LPHA who is providing DTI services or directing the program. (Depending on the writer, daily notes may need co-signature.)<br>• It is advisable occasionally to give an update as to where the client stands in the overall course of treatment, and to describe the client's reported medication reactions. (If a client is receiving meds from a physician outside the Department, make note of this and of the medicines received.)<br>• Changes in Service Plan or Diagnosis:<br>– If changes are made in the Client Recovery Plan or diagnosis, the reasons for these changes should be clear or should be explained in an ID note dated on or about the same date as the change in the plan or diagnosis |

**Billing**

For instructions on billing unique to day treatment can be found in the "Billing" section of this manual.

# Documentation in the Chart of Client Complaints

**Reporting options**

The following are options for reporting client complaints and incidents;

- Client complaints, including complaints about staff misconduct may be documented in the client's chart, to the extent that such documentation is necessary for follow-up client care
- The client may make his/her own report of the incident to the Quality Assurance system via the grievance forms available tin the lobby of each clinic
- Information regarding an alleged incident that is necessary for Departmental investigation and follow-up will be included in a DBH incident report

**Charting**

Charting related to alleged incidents of staff misconduct will be handled as follows:

- When the complaint is about staff misconduct, it is recommended that initials (and not Names) be used in the chart if it is necessary to identify the staff person at all
- The exact source of information should be identified if information regarding an alleged incident is reported in the chart in the following manner:
  - "The client reported that...", the clinic supervisor, John Doe, reported that...,"etc.
- It is charted in this way because if the provider did not observe the alleged incident, the provider does not know what actually happened

**Should information be included?**

If it is uncertain about whether or not to include certain information about an alleged incident in the chart, a provider may consult his/her clinic supervisor.

**Clinic Supervisor action**

The Clinic Supervisor will notify the staff person about whom the complaint is made regarding what information was entered in the client's chart.

**Staff action**

The staff person may request that this chart be treated as a chart containing "sensitive information".

# General Instructions for All Interdisciplinary Notes

**Names**

DBH chart notes are referred to in the following ways:

- Progress note
- Chart note
- Interdisciplinary note
- ID note
- “Pink note”

It is a chronological record of the course of the client’s care in the Department and should contain entries whenever the client does not keep or reschedule an appointment as well as notations of provider attempts to contact the client.

**Definition**

These notes are the narrative record in the chart of each client. An ID note is written for each of the following events in the course of treatment needing to be recorded for clinical or for legal purposes:

- Face-to-face contact
- Phone calls
- Collateral contacts
- Other events relevant to treatment

**Time deadline**

The following guidelines apply to the writing of case ID notes:

- Every ID note must be written not later than the day after the service occurs
  - Ideally each ID note would be written the day the services was delivered.
- Every ID note must be filed in the client’s chart no later than 72 hours after the service occurs

*Continued on next page*

# General Instructions for All Interdisciplinary Notes, Continued

**Purpose**

ID notes must both:

- Communicate with others who may need to take care of the client
- Document what every provider has done so that those paying for the services will be convinced that appropriate and needed services were delivered

**Placement in Chart**

The following policies apply to ID notes:

- ID notes are placed in the ID notes section of the chart
- ID notes for various services in the same clinic location will be entered chronologically without being separated by service mode. These services include:
  - Mental Health Services
  - Day Rehabilitation
  - Case Management, etc.
- When an MSS note page is placed on top of a partially filled MHS note page, MHS and other services dated after the date of the meds visit must be written on a new MHS ID page and not on the previous page
- All unused lines on the general ID note page are then diagonally lined out

**General instructions and billing**

The following are required headings for all notes:

- DATE
- SERVICE DELIVERY TIME
  - Together with charting time and any associated plan development time
- LOCATION
  - See codes at top of the ID note page, and also V-B
- SERVICE MODE AND TYPE
- EXAMPLES would be MHS – IND., DTR-Group, CM-Place., etc.
  - See list of service headings and abbreviations below and on the CDI
  - Example—4-31-95 1:05 1 MHS-IND.
  - See Billing Section for specific group billing instructions

*Continued on next page*

**Location**

- The first number of the location code indicates the location of the provider of the service when the service was provided
- These codes are printed at the top of the ID note page and on the CDI. "-3" is added if the service was not provided to a client face-to-face
  - For example, individual therapy in the provider's office with the client would have a location code of "1".
  - Individual therapy provided over the phone to a client when the provider is located in a phone booth in the community would have a location code "2-3".
  - Plan Development done in the office by the provider alone would be "1-3".

**Time entry**

Enter service time (plus charting and associated Plan Development time) in hours and minutes (one hour and 15 minutes is 1:15).

**Specific situations**

The following chart applies to specific situations in writing ID notes:

| If there are... | Then... |
|---|---|
| Multiple services where significant amounts of more than one service are provided in one session e.g. individual therapy and collateral: | • Write separate notes, and<br>• Bill separately. |
| Multiple staff where more than one staff member is involved in providing a service | • The initials and billing time of each staff member are listed in the "hrs.-min." column of the ID page<br>• Each staff member is identified by name and discipline in the ID note<br>• A sentence is included in the note telling who more than one provider was needed (except for services team meetings<br>• See Billing section for a group example |
| Service(s) provided by phone | • Head that note with the activity done followed by "phone"<br>• Individual therapy done in the office over the phone would be headed "MHS-Ind.-phone", with a location code of "1-3" |

*Continued on next page*

**Content**

ID note contents should be as follows:

| Every Note | On occasion | As needed |
|---|---|---|
| • A description of the client's current condition<br>• The problem or dysfunction being addressed in the session<br>• Provider interventions, and<br>• The client's response to the interventions | A description of where the client stands in the overall course of treatment | Medications effects |

**Change in plan or diagnosis**

When changes are made to the Client Recovery Plan or the client's diagnosis, an ID note dated on or near the date of the form change should be written to explain the reasons for the change

**Intensive outpatient**

ID notes for "intensive outpatient" services must describe several interventions and client responses, to justify the greater length of services.

**Dual-diagnosis services**

See "Dual-Diagnosis Services in DBH Outpatient Clinics" regarding documentation of dual-diagnosis services.

**Crisis intervention**

In addition to the "Content" section above, Crisis Intervention ID notes must contain a:

- Description of the acute crisis or dysfunction that jeopardized the client's ability to maintain usual community functioning
- Plan for subsequent service, if applicable

**Sign each note**

Sign each entry made. (See "Signatures" section for signature formats.)

**Unused lines**

Draw a vertical or diagonal line through every blank line left after an ID page is finished.

**Continuing a note**

If a note is continued from one page to the next write:

- "Continued" at the bottom of the first page and sign it
- The date and "continued' at the top of the new page

*Continued on next page*

**Client/Clinic information**

Each ID note page must include the following:

- Client's name
- Client's chart number
- Client's date of birth
- Name of clinic where the service was provided

**Service heading abbreviations**

The following are abbreviations used in the Service Heading:

| Abbreviation | Description |
|---|---|
| MHS | Mental Health Services |
| CM | Case Management |
| MSS | Medication Support Services |
| DTR | Day Rehabilitation (If written on the MHS ID note form |
| Pl. Dev. | Plan Development<br>Note: Pl. Dev. For MHS is headed "MHS – PL. Dev.", but Pl. Dev. for CM is headed "CM – L&C—Pl. Dev." |
| Ind. | Individual |
| Group | Psychotherapy group only |
| Coll. | Collateral |
| Assess. | Assessment |
| Psych. Test. | Psychological Testing |
| Cr. Int. | Crisis Intervention |
| Fam. Ther.—Ind. | Family Therapy if only one open chart |
| Fam. Ther.—Grp. | Family Therapy if two or more open charts |
| Meds. Visit | If not using MSS structured note |
| Meds. Support | If not using MSS structured note |
| CM – L&C | Case Management—Linkage and Consultation |
| CM—Place. | Case Management—Placement |
| Rehab/ADL<br>– Ind.<br>– Group<br>– Meds. Ed. Group<br>– Voc. | Rehabilitation/ADL |
| Voc. | Vocational |
| Drug S. | Drug Screen |
| Social. | Socialization |
| Eval. Or Evaluation | Would be appropriate heading for the Community Functioning Evaluation, which is no longer used. |

**Additional information**

Also see the CDI for exact abbreviations to use in ID note headings.

# Medicare Charting and ID Notes

**Policy**

All charting for Medicare-billable services will be done according to the instructions in the "General Instructions for All Interdisciplinary Notes" section of this manual.

**Current billable services**

The Medicare-billable services are currently:

- Crisis intervention
- Assessment
- Individual therapy
- Group therapy
- Psychological testing
- Family therapy
- Collateral as it pertains to the above services
- Medications

**Reports**

The MHS560 and MHS 100 reports identify clients with Medicare.

**Reference**

See "General Instructions for All Interdisciplinary Notes" for general instructions for all ID notes.

**Documents**

There are no required Medicare differences in the use of the:

- Clinical Assessment
- Diagnosis page
- Care Necessity form
- Client Recovery Plan
- Consent for Treatment

**Advance Beneficiary Notice**

The Medicare Advance Beneficiary Notice must be given to Medicare beneficiaries before any service that is not expected to be reimbursed by Medicare.

**SIMON**

SIMON translates the following from those described elsewhere in this chart manual to the formats required for Medicate billing:

- Diagnosis
- Billing time
- Service type
- Location

*Continued on next page*

**Acceptable services**

Medicare pays only for services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

**Goal of psychotherapy**

The Medicare goal of psychotherapy is to:

- Reduce or eliminate symptoms, complains, or impairments that interfere with normal functioning
- Stabilize (or improve) "at-risk" patients with chronic mental illness
  - Maintenance is acceptable as an ongoing goal is justified in relation to what would happen or has happened to the patient when treatment is discontinued

**Not billable to Medicare**

The following services are not billable to Medicare:

- Psychotherapy for persons who do not have the cognitive capacity to participate in the treatment
  - **Note:** A psychotherapy session cannot last longer than a patient's attention span
- MAA activities are never Medicare billable

**Not medically necessary or reasonable**

Psychotherapy is not medically necessary or reasonable when:

- There is lack of progress toward improved functioning
- There is deterioration by an SPMI patient being treated
- The therapeutic goal is achieved
- Cognitive or other organic problems, including dementia, preclude participation and benefit
- The patient is delirious
- Substance use interferes with ability to benefit
- The patient refuses to participate
- The patient only needs social, recreational or custodial services

**Dementia**

Psychotherapy for dementia alone is not appropriate, where as psychotherapy for dementia with depression may be.

*Continued on next page*

**Medicare payment**

Services for diagnoses not on the Medicare diagnosis list will not be paid.

The following services are not separately billable to Medicare:

- Collateral
- Plan Development
- Case Management

Rehab/ADL is currently not being billed to Medicare

**Patient education**

Patient education about the illness and telephone calls are included in service billings and are not billed separately.

**Consultation with Primary Care Physician**

It is required that at the beginning of care, non-M.D. providers:

- Inform the patient of the desirability of the therapist conferring with the patients PCP, and unless the patient declines
  - Document in chart if the patient declines this contact.
- Provide written notification to the PCP that services are being provided to the patient
- Consult with the PCP in case medical conditions are contributing to the psychological conditions

**ID Notes: Stand- Alone concept**

Medicare notes should give a reviewer enough information that they would not necessarily need to look at the Client Recovery Plan or Clinical Assessment. Medicare notes are more like traditional physician notes and must have more context and content than Medi-Cal notes.

**Medicare note specifics**

Use the following chart to determine what to include in the Medicare ID Notes.

| Placement | What to Include |
|---|---|
| In first note or two | Permission to treat: that the client signed the Consent to Treatment form |
| " | Relevant history of condition requiring treatment include in ID note even though it is in Clinical Assessment |

*Continued on next page*

**Medicare note specifics,** Continued

| Placement | What to Include |
|---|---|
| In first note or two | Patient's ability and willingness to resolve the mental problems present:<br>• Does the patient have both the ability to take advantage of the treatment and the motivation to do so in a manner that will make the treatment successful?<br>– "Client is of average intelligence and able to participate in psychotherapy. Client is fearful of failure but expresses almost desperate desire to improve depression and return to work." |
| " | Primary care physicians contact or status (include date of patient's most recent contact with PCP)<br>• I sent notice of proposed services here to Dr. Tolbert Gayton in Rialto, of<br>• "Client requested that we not contact his PCP Dr. Tolbert Gayton in Rialto" whom he most recently visited 1/30/06." |
| " | Treatment plan including:<br>• Therapeutic interventions<br>• Planned and duration estimate<br>– "Patient agrees to our recommendation of group psychotherapy lasting 16 weeks." |
| " | If not on meds, document reasons to refer or not to refer for meds. |
| " | If "interactive psychotherapy" is required, document why. |

*Continued on next page*

**Medicare note specifics,** Continued

| | |
|---|---|
| Include in every ID note | • Patient name (at bottom of ID note page is OK<br>• Date of service<br>• Billing time<br>• Patient's conditions, which should indicate continued need for treatment<br>– "For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service"<br>• What happened during the session in relating to the problem being treated<br>• Intervention used in that session<br>• Active participation by patient (more than just client response<br>• Progress made toward treatment goal<br>• Obstacles to treatment discovered (if any)<br>• Reason for lack of improvement (if none)<br>• Test and exam results (if any)<br>• Consultations and referrals (if any)<br>• Revisions to the diagnosis, goals, or treatment plan (if any)<br>– "See updated Client Recovery Plan as of this date."<br>• Immediate plan for care<br>– "RTC for next ind. ther. 2/27/06"<br>• Signature, legible name an degree of practitioner |
| Unusual Circumstances | • Long-term psychotherapy requires submitting an updated treatment summary and treatment plan when requested, with prediction of number of visits needed until end of calendar year.<br>• Visits longer than 90 minutes require a written report submitted with the claim<br>• Only exceptional circumstances warrant a 75-80 minute billing |

**Medicare payment prompts**

An ID note page with Medicare content prompts is available

# Medication Support Services ID Notes

**General**

See “General Instructions for All Interdisciplinary Notes” section for general instructions applying to all ID notes.

**Structured note form**

The following instructions apply to MSS ID notes:

- MSS ID notes will normally be written using the structured, Departmental pink form reserved for these notes only
- Any MSS notes written on the regular MHS ID note form will include the same content as required in the MS ID note form
- The MSS ID note content is considered to be part of the MSS plan of services

**Who can use the form**

The following instructions apply to those who are authorized to use the MSS ID notes:

- Parts A and B may be used by both physicians and R.N.’s
  – R.N.’s using Part A must include all required content for Part A
- Part B may also be used by psych techs administering medications
- Co-signature is not required for nurses and psych techs using the form to document services they provide that fall within their DBH-authorized scope of practice

*Continued on next page*

# Medication Support Services ID Notes, Continued

**Completing the form**

The following sections of the MSS ID notes must be completed as stated below:

| Section | Information to be Completed |
|---|---|
| Note Content | • All sections of Part A must be filled out for visits in which meds are prescribed<br>• All notes (Part A and Part B) must describe staff actions (prescribing meds., etc.)<br>• Fill in the date, billing time and service location |
| | All meds visit notes must include notations regarding:<br>• Target symptoms: the problem being treated<br>• The client's response to medications<br>• Side effects noted and actions taken in response<br>• Presence/absence of tardive dyskinesia<br>• Client compliance with the medication plan<br>• Medication interventions |
| | • If any part of the form is not applicable for a given visit, enter N/A<br>• Enter other information if relevant:<br>– Labs<br>– Recovery update, etc. |
| MSS Groups | • In order for MSS—Group to be charted and billed, the note must contain description of some group process—at a minimum, a group discussion of compliance and/or side effect issues<br>– "Groups" that involve only separate, individual services (and no group interactions) for individuals who happen to be in the same room at the same time should not be charted or billed as group |

**Termination**

If it is planned to terminate medication services at a site, the provider planning the termination should notify all other providers of services to the individual at that site.

# Abnormal Involuntary Movement Scale (AIMS)

**Purpose**

This form helps the physician to stay alert regarding involuntary movement effects of medications.

- The form will be completed on all clients being prescribed medications, to establish a baseline
- It will then be repeated annually for those clients receiving neuroleptics

# Clozapine Side Effect Checklist

**Description**

The Clozapine Side Effect Checklist is used to keep a running record of side effects by the week.

**Completing the form**

The following steps detail completion of this form:

| Step | Action |
|---|---|
| 1 | • Each column represents a week<br>• Identify the date above and fill in the boxes for each week as indicated, by a check mark or with data regarding that item |
| 2 | Physician initials must be entered at the bottom of each column |
| 3 | Additional explanation of items may be written at the bottom, and any side effects should also be noted in the MSS ID note for that visit |

# Local Medical Review Board

**Codes**

The following is a CD – 9- CM Codes that Support Medical Necessity (from NHIC materials). Services for other diagnoses will not be paid.

| Acceptable CD-9-CM Codes | Associated Diagnosis Description |
|---|---|
| 290.12 | Presenile dementia with delusional features |
| 290.13 | Presenile dementia with depressive features |
| 290.20 | Senile dementia with delusional features |
| 290.21 | Senile dementia with depressive features |
| 290.42 | Arteriosclerotic dementia with delusional features |
| 290.43 | Arteriosclerotic dementia with depressive features |
| 291.5 | Alcohol Jealousy |
| 291.81 | Alcohol Withdrawal |
| 291.89 | Other specified alcohol psychosis |
| 291.9 | Unspecified alcohol psychosis |
| 292.0 | Drug withdrawal syndrome |
| 292.8 | Drug-induced organic affective syndrome |
| 292.89 | Other drug-induced organic personality syndrome |
| 292.9 | Unspecified drug-induced mental disorder |
| 293.81 | Organic delusional syndrome |
| 293.82 | Organic hallucinosis syndrome |
| 293.83 | Organic affective syndrome |
| 293.84 | Organic anxiety syndrome |
| 293.9 | Unspecified transient organic mental disorder |
| | Other specified organic brain syndromes (chronic)<br>• Epileptic psychosis NOS<br>• Mixed paranoid and affective organic psychotic states |
| 295.00 – 295.95 | Schizophrenic Disorders |
| 296.00 – 296.99 | Affective psychoses |
| 297.1 | Paranoia |
| 297.3 | Shared paranoid disorder |
| 298.8 | Other and unspecified reactive psychosis |
| 298.9 | Unspecified psychosis |
| 299.00 | Infantile autism, current or active state |
| 299.10 | Disintegrative psychosis, current or active state |
| 299.80 | Other specified early childhood psychoses, current or active state |
| 300.00 – 300.9 | Neurotic Disorders |
| 301.1 – 301.9 | Personality Disorders |

*Continued on next page*

**Codes,** continued

| Acceptable CD-9-CM Codes | Associated Diagnosis Description |
|---|---|
| 303.90 – 303.92 | Other and unspecified alcohol dependence |
| 304.00 – 304.92 (excludes -.03) | Drug dependence, excludes remission subtype **use only the fully detailed codes* |
| 305.00 – 305.92 (excludes - .03 | Nondependent abuse of drugs, excludes remission subtype **use only the fully detailed codes* |
| 306.0 – 306.9 | Physiological malfunction arising from mental factors |
| 307.0 – 307.9 | Special symptoms or syndromes, not elsewhere classified |
| 308.0 – 308.9 | Acute reaction to stress |
| 309.00 – 309.9 | Adjustment reaction |
| 311 | Depressive disorder, not elsewhere classified |
| 312.30 | Disorders of impulse control, not elsewhere classified |
| 312.33 | Pyromania |
| 312.34 | Intermittent explosive disorder |
| 312.81 – 312.89 | Other specified disturbance of conduct, not elsewhere classified |
| 312.9 | Unspecified disturbance of conduct *(delinquency, juvenile)* |
| 313.0 – 313.9 | Disturbance of emotions specific to childhood and adolescence |
| 314.0 – 314.9 | Hyperkinetic syndrome of childhood |
| 315.5 | Mixed development disorder |
| 315.8 | Other specified delays in development |
| 315.9 | Unspecified delay in development |
| 316 | Psychic factors associated with diseases classified elsewhere |
| 780.52 | Other insomnia |
| 995.50 – 995.59 | Child maltreatment syndrome |
| 995.80 | Adult maltreatment, unspecified |
| 995.81 | Adult physical abuse |
| 995.82 | Adult emotional abuse |
| 995.83 | Adult sexual abuse |
| 995.84 | Adult neglect (nutritional) |
| 995.85 | Other adult abuse and neglect |
| V11.0 – V11.9 | Personal history of mental disorder |

# Medications Order Sheet

**Directions**

Complete all columns (except problem number):

- Date/time
- Medicine
- Dosage
- Frequency
- Route/site of entry
- Number of tablets on hand
- New amount prescribed
- Refills
- Signature

**Note:** For intramuscular administrations, it is critical to include the time and site of the injection.

**Ability to manage meds**

A notation regarding the client's ability to manage his/her own medications must be made at the bottom of each Medications Order Sheet.

# Clinical Laboratory

**Policy and procedure**

There should be a baseline laboratory study appropriate to the medication prescribed and annual laboratory studies thereafter. Laboratory reports from an outside clinic or agency within the past year are acceptable.

**Specific meds**

Appropriately-timed blood level findings should be obtained and on file for clients taking the following medications

- Lithium
- Tegretol
- Dilantin
- Phenobarbital
- Others requiring frequent monitoring

# HIV and Aids Charting

**Introduction**

See the following statement from the Department's Standard Practice Manual.

**Policy**

Since HIV testing is to remain as confidential as possible in order to encourage more people to consent to be tested, HIV/AIDS status which has been determined by testing in the OADP HIV/AIDS testing and counseling program is to be treated as confidential.

**Disclosure of information**

Testing program staff will not disclose or release this test status information to anyone without the individual's written permission on the release of information form or as otherwise permitted by law, for example to:

- Employees in DMH or OADP whose work involves contact with bodily fluids of clients.)

**Notation of information**

The law permits notation by HIV/AIDS testing and counseling program staff of HIV results in OADP and DMH client charts, but in order to promote early detection, DMH policy allows OADP HIV/AIDS testing and counseling program staff not to place this HIV/AIDS information in OADP or DMH charts

**Reference:** Health and Safety Code 199.20 et seq; 42 C.F.R., Para. 2

**DMH medical records**

Charting by DMH or OADP clinicians or physicians of a client's HIV test results or AIDS diagnosis does not require client authorization if obtained appropriately from:

- Other medical records
- Collateral persons
- Client's disclosure

**Reference:** California Hospital Assoc., Consent Manual 19965 Edition, Chapter 20.

*Continued on next page*

**Clinician/ Physician decision**

Clinicians and physicians may decide whether to chart known HIV/AIDS information regarding a client, but if such information is not charted, the risks of not charting this information to the following persons should be carefully considered:

- Client
- Clinician
- Other health care workers

**Where diagnosis is reported**

When a client's HIV positive status or AIDS status is charted, the HIV – positive status or AIDS diagnosis can also be recorded on Axis III of the DSM-4 diagnosis if it is relevant to the appropriate management of the case.

**Disclosure by staff**

Disclosure of a client's HIV/AIDS status through:

- Oral communications
- Written communications
- Disclosure of the medical recorded

Requires that the client specifically authorize the HIV/AIDS disclosure in writing, using the release of information form, except in the following circumstances:

- To another health care practitioner or an agent or employee thereof who provides the client's direct care and treatment. Authorized disclosure under this section does not include:
  - Certain health care services plans. Disclosures to insurance companies are governed by Insurance Code 799 et. seq.
  - Non-treatment personnel of any kind (clerks, janitors, etc.)
- To the clients legal representative, conservator, or the person who gave consent to the client's HIV test;
- To a provider of health care who procures, processes, distributes, or uses a human body part donated pursuant to the Uniform Anatomical Gift Act

**Reference:** California Hospital Association, Consent Manual, 1995 Edition, Chapter 20:

*Continued on next page*

**Procedure for release of information**

The following procedure is used when releasing information regarding the client's HIV/AIDS status.

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Any DMH employee involved in obtaining client consent to the release of DMH confidential information will ask the client:<ul><li>"Is there any reason to think that HIV or AIDS information about you might be included in your medical record?"<ul><li>The client may indicate at that point, without answering the question, that he/she wishes to competed the release process with a specific other person, such as his/her clinician or physician.</li></ul></li></ul></td></tr>
<tr><td>2</td><td>
<table>
<tr><th>If the client answers...</th><th>Then...</th></tr>
<tr><td>"No" and the staff person involved knows of no HIV/AIDS information in the record,</td><td>The release process will proceed as usual</td></tr>
<tr><td>"Yes" (or if the client answers "No" but the DMH staff persons involved know that such information is included in the record),</td><td>The client will be asked if he/she wishes to consent to release of both psychiatric and HIV/AIDS information in the record.</td></tr>
</table>
</td></tr>
<tr><td>3</td><td>
<table>
<tr><th>If...</th><th>Then...</th></tr>
<tr><td>The client Consents to the release of both psychiatric and HIV/AIDS information,</td><td>That fact will be noted non the release form (by writing in the "SPECIFIC TYPES OF INFORMATION" blank "Client consents to the release for any HIV/AIDS information in the recorded at this time").</td></tr>
<tr><td>The client does not consent to the release of HIV/AIDS information,</td><td>That fact will <u>not</u> be noted on the release form.</td></tr>
<tr><td>The client consents to disclosure of psychiatric information but not HIV/AIDS information,</td><td>Disclosures must be so edited and HIV/AIDS information removed from the disclosure, unless otherwise permitted or required by law</td></tr>
<tr><td>Editing of HIV/AIDS information is needed prior to a disclosure of client information</td><td>A clinician or physician will do this editing, using the directions of Medical Records regarding how to carry out the editing.</td></tr>
</table>
</td></tr>
</table>

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**Disclosures to persons in danger of harm**

The physician who ordered the antibody test may disclose confirmed positive test results of his or her patient to:

- A person reasonably believed to be the spouse of the patient
- A person reasonably believed to be a sexual partner
- A person with whom the patient has shared the use of hypodermic needles
- The County Health officer

A physician shall not be held civilly or criminally liable for doing so. Prior to disclosing the test result to a third party, a physician must first:

- Discuss the results with the patient
- Counsel the patient
- Attempt to obtain the patients' voluntary consent to notify the patient's contacts

Also, when the physician discloses the information to a contact, the physician must refer that person for appropriate care.

**Reference:** Health and Safety Code 199.25

**Court case**

A recent California Court of Appeals decision (Reisner v. Regents of University of California [1995] 31 Cal App. 4th 11-95) indicates that in certain situations physicians may have a duty to warn those who could be harmed by a client's HIV infection. If medical staff are unsure how to proceed in these circumstances, even after carrying out the permissive disclosure in the immediately preceding instructions, see CONSULTATION SECTION below.

**Permissive or discretionary disclosure**

To date, there is not statutory authorization for permissive or discretionary disclosure of a client's AIDS/HIV status to those described in the immediately preceding instructions by a treating non-physician without a release of information by the client. (See CONSULTATION SECTION below.)

**Mandated reporting - general**

The law imposes a duty on medical or other personnel providing services in adult correctional or juvenile detention facilities to communicate to the officer in charge information that indicates that an inmate or minor at the facility has been exposed to or infected by the HIV virus.

*Continued on next page*

**Specific requirements**

There are currently no mandatory reporting requirements regarding HIV test results or HIV status, but there are reporting requirements regarding a diagnosis of actual AIDS. The following criteria shall be followed:

**Reference:** California Hospital Association, Consent Manual, 1995 Edition, Chapter 20.

| Who Reports | Required Reporting |
|---|---|
| DMH physicians who makes a diagnosis of AIDS | Should report it immediately to the County Public Health Officer (909) 383-3060 |
| Physicians and hospitals | Must immediately report all transfusion-associated AIDS cases confirmed by the person's physician to the County Health Officer for investigation. |
| Hospitals | Must report to the State Department of Health Services and the County Health Officer whenever a person is hospitalized whose physician confirms that the person has a diagnosis of AIDS |

**When report are made**

Reports must be made as soon as practicable after hospitalization. These reports must include:

- The person's name
- The person's date of birth
- The person's address
- The person's social security number
- Hospital name
- Date of the person's hospitalization

**Liability**

There is no liability for hospitals and physicians making these required reports.

**Legal requirement**

There is no legal requirement that the client be notified regarding these reports.

**Consultation**

Disclosures of information regarding a person's HIV and/or AIDS status may present legal issues, including occasionally the issue of possible Tarasoff warnings. In the event that a question regarding disclosure is not covered in the material set forth hereinabove, follow the steps below:

| Step | Action |
|---|---|
| 1 | The clinician's supervisor should be consulted concerning the propriety of releasing confidential information in that given situation. |
| 2 | County Counsel can only be contacted via Department administration, by first contacting one's Program Manager II. |

# Physical Assessment

**Description**

Form 18x (yellow):

- Verifies that the physician has discussed with the client the need for the client to have a complete physical examination
- Allows client and physician to be fully aware of the client's physical condition and of any contraindications to the use of psychotropic medications

**Completing the form**

Form 18x is completed as follows:

- The client should be reminded of this annually and the form filled out and signed by the client every year
- The form should be filled under the "Physical" tab in the back of the chart
- A copy of a physical examination from another facility, such as County Medical Center or Ward B, can be filled in the chart in lieu of Form 18x

# AB2726 Financial Liability for Parents

**Description**

Parents of children being evaluated for or receiving AB2726 services must be informed of certain financial information regarding payment for the child's services. The form headed "AB2726 Financial Liability" is the record of this process.

This form also details what parents should expect from DMH in the course of evaluation and services

**Procedure**

The following procedure applies to completion of the form:

| Step | Action |
|---|---|
| 1 | Parent signs form indicating that they have been informed of these matters. |
| 2 | A DMH witness should also sign the form |
| 3 | After signatures are obtained, parents shall be given a copy of the form. |
| 4 | File the from under the "Identification" tab in the back of the chart. |

# Charting Interpretation and Service in Non-English Language

| | |
|---|---|
| **Entry detail for interpretation of a service** | The person writing the chart note will enter, immediately following the service name (MHS-Ind. Ther.", etc.), "(Interpretation provided in [Specify language] by [name of provider]". |
| **Example** | MHS-Ind. Ther. (Interpretation provided in Spanish by Adam Articulate)... |
| **Entry detail for provision of service** | Charting provision of service in a non-English language involves the person writing the chart note will enter, immediately following the service name "(Provided in [specify language])" |
| **Example** | MHS-Ind. Ther. (Provided in Vietnamese)... |

# Child Abuse Reporting Forms

**Process**

After a required child abuse report has been made, a copy of the Child Abuse reporting form will be placed in the Correspondence section of the minor's chart.

# Discharge Summary

**Description**

The Discharge Summary describes briefly the:

- Reason for the client's treatment
- Course of treatment
- Client's condition on discharge

**Which cases must have a DS**

A Discharge Summary must be completed as follows:

- On all cases open more than two months
- For all cases, an ID note is written at least noting the discharge
- In cases open less than two months, this ID note should explain the above items

**Timing**

Discharge Summaries must be completed within the following time frames:

| If... | Then... |
|---|---|
| It is unclear whether the client will return for further services | The Discharge Summary will be completed no later than six months from the last service |
| No further treatment is planned. | The Discharge Summary will be completed within one month of a clear termination |
| A client has a planned absence of somewhat more that six months, but it is planned that the client will return for further treatment and if the rationale for this is explained in the ID notes. | The chart may be kept open for longer than six months |

**Completing the form**

The following instructions apply to completion of the Discharge Summary:

- All parts of the form must be completed
- Indicate what services are being terminated:
  - MHS
  - DTR
  - MSS, etc.

- If the client is receiving medications upon discharge, fill in the names of those medicines
- "Admission Date" is the date of entry or registration for the client
- Date of Last Documented Client Contact is the date of the last clinical service involving actual contact with the client

See "Chart Closure" section for related information.

# General Report Form

**Purpose**

The General Report Form may be used as a formatted form for typing any report. All relevant information is filled in at the top of each page used.

# Notice of Action Forms

**Requirement**

The following requirements apply to the receipt of Notice of Action forms:

| When... | Then... |
|---|---|
| A Medi-Cal (or other Notice of Action) is given to a client, indicating a denial of services | A copy of the Notice of Action form will be placed in the chart (in the Legal section) |
| The chart is closed and episoded | This form will be placed in the episode according to instructions from the Medical Records Office |

# Advance Directives

**Description**

Advance directives:

- Provide instruction on how a person wants his/here future healthcare to be carried out
- Have legal standing and should be honored by all healthcare providers. when properly prepared
- May address psychiatric care as well as other healthcare areas

**Requirement to notify**

The State Department of Mental Health requires:

- DBH to inform adult clients upon entry about advance directives
- Those clients have the right to establish directives

**Note:** Advance directive notification is not required for minor clients

**Where information is found**

Reference to this is in the DBH Consumer Brochure, and detailed materials being developed on the subject are part of the information that all sites and providers are required to provide to clients in waiting rooms.

**Use of form**

The DBH Advance Directives Notice form is used to advise all providers whether or not the client has established advance directives. The following information is recorded on the form:

- If the client reports that he/she has no advance directives that will be noted in the top section of the form
- If advance directives are completed here, or if the client brings to us a copy, these will be filed with the Notice form in the chart section that contains consents for treatment
- The client may also tell us that advance directives are at another location a physicians' office, and agency etc. and that other location will be recorded on the Notice form
- Clients will be informed that they can bring a copy of current advance directives for inclusion in the DBH chart
- Additional a sections of the form will be completed if the client changes his/her advance directives or where they can be obtained

*Continued on next page*

**Responsibility to follow advance directives**

The client's advance directives will be followed in almost all cases, however use the following chart in these two situations:

| If... | Then... |
|---|---|
| A provider believes that for some reason an advance directive should not be honored | Supervisors and County Counsel should be consulted |
| It is known that an advance directive exists, and a critical healthcare decisions must be made, | That advance directive should be consulted, whether or not it is in the DBH chart. |

# Authorization to Obtain Medical Care for Minor

**Purpose**

This form, labeled "MED. CARE AUTHORIZATION FOR MINOR," enables a person with medical care rights regarding a minor (such as a parent or legal guardian) to authorize, in advance, DBH clinic staff to obtain medical care for the minor that should become necessary while the minor is in the care of the clinic and the parent is not available.

**Example:** A child falls or is cut while in a session and parents are not in the clinic.

**Procedures**

The following procedures apply to completion of this form:

- It is recommended that clinics have this form completed for each minor client at the time of registration and treatment consent
- Any non-parent who signs this form must produce documentation to prove their custodial and/or medical rights, just as they must do in order to be allowed to sign the treatment consents
- The form must be witnessed (with signature) by DBH staff
- Staff must take this form with them to the medical facility if they take the minor for care

# Authorization to Release Confidential (Protected) Health Information

**Policy**

The form "Authorization to Release Confidential Protected Health Information" is used both to request information from other sources and to release DBH information regarding a client.

**Completion of authorization**

Following are procedures for completing the authorization:

- Make sure that the client understands what information will be released and any foreseeable consequences of the release
- Enter name of facility releasing information after "I AUTHORIZE:"
- Enter name of facility receiving information above "Facility Name."
- If possible, the name of a specific person who is to receive the information is required

If DBH is releasing information, enter the specific purpose(s) for the release (e.g., SSI application, inform client's new therapist, provide required probation reports, etc.).

Check information to be released, or describe in "Other." Only information necessary for the purpose listed above should be released. (It is very rare that an entire chart would be copied and released.

**Use of authorization**

An authorization, once signed, may not be used to justify future releases of information unless these are exactly the same as described in the release, are intended by the authorizing person to occur when signing the release, and occur before the expiration of the release.

The authorizing person has a right to a copy of the release. It is good practice always to give a copy to the authorizing person.

**Cancellation of authorization**

The client or client representative (conservator, person with medical consent rights for a minor) may cancel the release in writing at any time. If not cancelled specifically, an authorization terminates 90 days from the date of signature, or if so checked on the form, (1) on completion of the requested action, or (2) one year from the date of signature or the date the client's chart is closed, whichever comes first.

**Release of health information**

Protected health information (PHI) received from other sources should usually not be released by DBH to another facility. Clients are informed that DBH cannot guarantee that facilities receiving PHI from DBH will not release it themselves to other facilities. (Only alcohol and drug related PHI is legally protected from such re-release, as noted on the release form.)

*Continued on next page*

# Authorization to Release Confidential (Protected) Health Information, Continued

**Signatures on release forms**

The person signing the release must be the client or a person having medical consent rights for the client, such as a DCS worker or conservator. All persons besides those reasonably believed to be the parents of a minor client must provide written proof of their right to make medical decisions for the client.

Requests for PHI, once completed, will be forwarded to the current provider treating the client. The provider will sign the form (or not sign the form, if he/she wishes to deny the release based on client welfare).

**Release information rules**

When the protections afforded confidential/PHI information are different in California law and in HIPAA, the rule affording greater protection will be used. Thus, if HIPAA permits release but state law, as embodied in Welfare and Institutions Code 5328, does not allow it, the information will not be released. In problem situations, supervisors should be consulted.

**Note:** See the Department's Standard Practice Manual for rules relating to a client's request for information from his/her own chart that DBH providers do not believe is in the client's best interest.

# Consent for Treatment

**Description**

The Outpatient Consent for Treatment explains certain conditions of treatment, including circumstances under which confidential information may be disclosed without the client's consent.

**When form is signed**

The form should be signed by the client or responsible guardian, conservator, etc. before the client receives professional services, if at all possible, or as soon as possible thereafter

**Services in the field**

When initial services are provided in the field (no clinic visit), if, face-to-face contact with the person being helped occurs then an Outpatient Consent for Treatment will be signed by the person (or other person with legal consent rights).

**Minors**

Consent forms are accessible in English and Spanish. Note that the following persons do not automatically have the right to consent to this treatment:

- DPSS workers
- CPS workers
- Foster parents
- Legal guardians

These persons will not be allowed to consent to treatment for minors unless they have the authorization to do so in writing.

**Filing written authorizations**

If any person other than a parent signs for consent, his/her written authorization to do so will be placed in the chart. This includes copies of:

- Guardianship
- Conservatorship orders
- DPSS court authorizations to consent to treatment

*Continued on next page*

# Consent for Treatment, Continued

| | |
|---|---|
| **Therapy vs. medications** | Note that consent for psychotherapy or counseling, for adults or for minors, does not imply consent for the use of psychotropic medications (which must have separate consent). |
| **Conservatees** | In the case of a client who is under conservatorship, the conservator must authorize all non-emergency outpatient care. |
| **Medi-Cal** | All Medi-Cal eligible clients must have their attention drawn to item 10 of the consent form, which indicates that receiving mental health services is not a prerequisite for access to other community services, and that the client may seek other providers and services when they are desired. |
| **Witness** | A Departmental representative (clerk or professional) must sign the form also, as “witness” |
| **Filing** | The form is filed in the center (middle) section of the chart, on the right hand side. |
| **Copy for client** | The client is given a copy of the signed consent form. |
| **Consent form in another language** | See 4.9.1 for procedures for the use of a consent form issued by the Clinical Records Committee in a language other than English. |

# Consent to Sound or Video Record

| | |
|---|---|
| **Usage** | The Consent to Sound or Video Record form will be used to document client consent for recordings of client sessions. |
| **Purpose of recording** | The specific purposes for which the recording will be used must be specified, and the date of consent expiration must be listed. |
| **Decision to consent changes** | If the client changes his or her mind and wishes to cancel the consent, this is documented on the same form. |
| **Filing form** | The form is filed along with the other treatment consents in the chart. |

# Medicare Advance Beneficiary Notice

**Purpose**

The Medicare Advance Beneficiary Notice is used to notify Medicare clients that a certain service may not or will not be reimbursable by Medicare.

**Frequency**

The Medicare ABN is filled out and signed by the client in advance of every service that may not or will not be reimbursable by Medicare (except that only annual notice is necessary regarding a service that is never covered by Medicare.)

**Procedure**

The following procedure is followed when completing the Medicare Advance Beneficiary Notice:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>The client’s name and Medicare number (if available) are entered at the top of the form.</td></tr>
<tr><td>2</td><td>The client is told that the service in question may not or will not be reimbursable by Medicare.<ul><li>The form is pre-printed with information about services that are not covered and the reasons why this might be so</li></ul></td></tr>
<tr><td>3</td><td>In the “Items or Services” box, write the name(s) of the service(s) in question. The reason(s) each service in question may not or will not be reimbursable is (are) indicated in the “Because” box by checking the appropriate box or writing in the reason.</td></tr>
<tr><td>4</td><td>The following actions will be taken should the client ask questions at this point:</td></tr>
<tr><td></td><td><table><tr><th>If the client...</th><th>Then the...</th></tr><tr><td>Asks the potential cost of the service to himself/herself,</td><td>Estimated cost is entered in the appropriate space on the form.</td></tr><tr><td>Does not ask the cost</td><td>Enter “did not ask”.</td></tr></table></td></tr>
<tr><td>5</td><td>The client checks option 1 or 2, indicating that he/she wants or does not want to proceed with the service, and signs the form.</td></tr>
<tr><td>6</td><td>Retain the original signed form, and give a copy to the beneficiary. If the client refuses to sign but demands the service, note on the form that the client refused to sign but demanded the service.</td></tr>
</table>

**Filing**

The originals of the form are filed as the top paper in the “Identification” section in the back of the chart.

# Medications Consent Form

**When completed**

The medications consent form should be completed the first time the physician prescribes medication for a client.

**Completing form**

The following steps in completing the Medications Consent Form:

| Step | Who completes | Action |
|---|---|---|
| 1 | Physician | Gives the client the information explanations called for in the top section. |
| 2 | Physician | Signs and dates the top portion. |
| 3 | Physician | Writes in the medication name in the bottom section |
| 4 | Client | Dates and signs that line in the bottom section |

**New form necessary?**

Use the following table to determine if a new form is necessary:

| Situation | New Form Needed? |
|---|---|
| Another physician fills in for the client's regular physician | No |
| A new physician takes over the case | No |
| A new episode is opened for the client | Yes |

**Discontinued meds**

If a previously used but discontinued medication is started again, a new line on the form need not be completed.

**Re-writing the form**

There is not requirement for re-writing the form based solely on how long a form has been used.

**Form in another language**

See 4-9.1 for procedures for use of a Medications Consent Form issued by the Clinical Records Committee in a language other than English.

# Telepsychiatry Consent

**Purpose**

The DBH Telepsychiatry Consent form will be used, in addition to the regular Outpatient Consent Form, whenever telehealth/telemedicine services are provided.

# Treatment Consent Delegation

**Purpose**

In some cases, parents or other persons with medical consent rights for a child may be unable to come to a clinic to consent to treatment for the child.

- Also see 7-1.6 for other parameters regarding consent in cases of minors

**Procedure**

The following rules apply to completion of the Treatment Consent Delegation:

- This form may only be used if the parent is physically unable to be present, because of being:
  - Housebound,
  - Incarcerated, etc.
- It may not be used to gain consent in case in which parents are simply uninterested or unwilling to come
- The signature of a witness who observes the parent or other delegating person sign the form must be included
- The person receiving treatment consent delegation must show, in addition to the delegation form, a copy of an ID showing the delegating person's signature so that we may affirm that the signature on the delegation form is genuine
  - This ID copy is filled in the chart with the delegation form, in the place where other consent forms are filed.
- The back (or second page) of the form should be used by the delegating parent or other person to give information about the child's recent medical care

# Confidential Record Release within County without Client Authorization

**When the client files a lawsuit**

When a client files a lawsuit against the Department or the County for personal injuries, the State's Evidence Code and Civil Code provide that those accused have access to the client's recorded of care.

**Client consent to access**

This access to client records may be without client consent or knowledge. When there is no client consent:

| If the chart is... | Then The Confidential Record Release within County without Client Authorization form will be filled out and filed in the chart by the... |
|---|---|
| Open | Clinic Clerk |
| Closed | Central Medical Records |

# Request for Release of Confidential Information to the Patient's Rights Advocate Office

**Patient's Rights Advocates access**

In the appropriate discharge of their duties, patient's rights advocates need access from time to time to client charts, either for:

- Investigation of possible rights violations, or
- Required monitoring of client's rights in facilities.

**Client signature**

When the client is available to sign a release of information form for these uses of the record, this will be accomplished. However, access to client records may be without client knowledge or overt consent in some instances, and in those instances the self-explanatory form (title above) will be filled out by the advocate and filed as follows:

| If there is... | Then the form will be entered in the chart by... |
|---|---|
| An open chart, | The record clerk of the clinic. |
| A closed chart, | Central Medical Records. |

# Letters "To Whom It May Concern" Requested by Clients

**Purpose**

From time to time clients may request that staff provide them with letters "to whom it may concern" which the clients can take with them and show to whomever they wish.

**Use by clients**

Clients may wish to use such letters as:

- Introductions to future treatment personnel, or
- Proof to an agency that they have received services, or
- Receipt of a certain diagnosis, etc.

**General policy**

**In general**, in accordance with the regulations of Title 22, such letter **should not be provided**. The reason for this is the concern that the client may give the information to someone who:

- Will use it to harm the client, or
- Is not bound by the regulations which prohibit re-release of the information to another party.

**Requests from future treatment personnel**

Any need of future treatment personnel for records should be met by a request from those personnel to DMH for the records, with a proper release from the client.

**Justifiable exception**

If there seems to be a justifiable exception to the above prohibition, then the purposes for which the client anticipates using the letter should be carefully discussed with the client, to make sure that such use:

- Would be in the client's best interest, and
- That the client is not intending to use the information in a deceptive or inappropriate way.

**Exception procedure**

If it is decided that such an exception exists and that a letter is to be provided then the following procedure applies:

| Step | Action |
|---|---|
| 1 | Release of information form should be signed by the client. |
| 2 | Details of the anticipated uses of the letter must be provided. |
| 3 | Release of information form is given to the client. |

*Continued on next page*

# Letters "To Whom It May Concern" Requested by Clients,
Continued

**Facts vs. opinions**

In general, such letters should confine themselves to the facts of a client's care in this department. The more the letters depart from the facts and go into areas of opinion or speculation, the more likely it is that the information could be misused.

**Approval**

All "To Whom it May Concern" letters must be reviewed by the Clinic Supervisor for appropriateness.

| If the Clinic Supervisor... | Then he/she will... |
|---|---|
| Approves, | Initial the letter |
| Does not approve, | Not release the letter |

**Required paragraph**

All "To Whom it May Concern" Letters will contain the following paragraph:

Any person receiving this letter should note that California Title 22 regulations prohibit him/her from giving this letter or a copy of this letter to anyone else, or informing anyone else of any of the information contained in this letter, without the client's specific written permission. Furthermore, the person about whom this letter is written (or his/her legal guardian or parent) has been informed that in giving this letter to anyone, he/she assumes a certain risk regarding the future safeguarding of the information.

**Release at a later date**

"To Whom it May Concern" letters should never be released at later times to any other parties, without the client's specific consent.

# Abbreviation List

**Abbreviations**

The following list shows common abbreviations used in this handbook as revised on March 1, 2004.

| Abbreviation | Description |
|---|---|
| AA | Alcoholics Anonymous |
| AB2726 | School Referred SED Children for State Program |
| ABC | Augmented Board and Care Homes |
| ABPP | American Board of Professional Psychology |
| ACOA | Adult Child(ren) of Alcoholics |
| ADD | Attention Deficit Disorder |
| ADHD | Attention Deficit Hyperactivity Disorder |
| ADL | Activities of Daily Living |
| admin. | administration |
| Adol. | Adolescent |
| ad.-bro. | adoptive brother |
| ad.-dau. | adoptive daughter |
| ad-â / ad.-fa. | adoptive father |
| ad.-Ⓜ/ ad.-mo. | adoptive mother |
| ad.-sis. | adoptive sister |
| ad.-son | adoptive son |
| â/fa. | father |
| ADS | DBH Div. of Alcohol and Drug Services |
| A/H | Auditory hallucinations |
| AIDS | Acquired Immune Deficiency Syndrome |
| AKA | Also known as |
| A.M. | Ante Meridiem = morning |
| AMA | Against Medical Advice |
| AMAC | Adults Molested as Children |
| approx. | approximately |
| appt. | appointment |
| APS | Adult Protective Services |
| ARMC | Arrowhead Regional Medical Center |
| ARMC-BH | Arrowhead Regional Medical Center – Behavioral Health |
| ARTS | Adult Residential Treatment System |
| ASAP | As soon as possible |
| ASI | Addiction Severity Index |
| assess. | assessment |
| assoc. | association |
| asst. | assistant |
| A/V/H | Auditory and Visual hallucinations |
| AWOL | Absent without leave |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| B.A. | Bachelor of Arts |
| BAL | Blood Alcohol Level |
| Basis-32 | Behavior and Symptom Identification Scale |
| B&C | Board & Care |
| BCD | Board Certified Diplomate (Social Work) |
| B/F | Boyfriend |
| BFCS | Bilingual Family Counseling Services |
| BHRC | Behavioral Health Resource Center |
| BIB | Brought in by |
| B.I.D. | Twice a day (Latin - bis in die) |
| BM | Bowel movement |
| BP | Blood Pressure |
| bro. | brother |
| B.S. | Bachelor of Science |
| BUN | Blood Urea Nitrogen |
| CalWORKS | CalWORKS |
| CAFAS | Child and Adolescent Functional Assessment Scale |
| CA-QOL | California Quality of Life Scale |
| canc. | cancelled |
| cap | capsules |
| CARF | Committee on Accreditation of Rehabilitation Facilities |
| CARS | Child Assessment Referral Services |
| CDSB | Casa de San Bernardino |
| CBC | Complete Blood Count |
| CBCL | Child Behavior Checklist |
| CCC | Community Client Contact |
| CCICMS | Centralized Children's Intensive Case Management Services |
| CD | Chemically dependent |
| CERT | Fourteen day certification |
| CFE | Community Functioning Evaluation |
| CHF | Congestive heart failure |
| CID | Center for Individuals w/Disabilities |
| Cl., cl. | Client |
| Cl. Pl. | Client Plan |
| CLEP | Client Living Environmental Profile |
| clin. | clinician |
| Clin.Th. | Clinical Therapist |
| C&L | Consultation and Liasion |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| CM | Case Management |
| C.Mgr | Case Manager |
| CMDC | Chino Multiple Diagnosis Clinic |
| CNS | Central Nervous System |
| CODA | Codependents Anonymous |
| coll. | Collateral |
| conj. | Conjoint |
| CONREP | Conditional Release Program |
| CONS | Conservatorship |
| Consult | Consultation |
| cont. | continued |
| COTA | Certified Occupational Therapy Assistant |
| CPS | Child Protective Services |
| CSQ-8 | Client Satisfaction Questionnaire |
| CSOC | Children's System of Care |
| CSOC-TAT | CSOC Technical Assistance Team |
| CSW Int. | Clinical Social Worker Intern |
| CT Scan | Computerized Tomography Scan |
| CYA | California Youth Authority |
| CWIC | Crisis Walk-In Clinic |
| dau. | daughter |
| day tx | day treatment |
| DAAS | Department of Aging and Adult Services |
| DBH | Department of Behavioral Health (San Bernardino) |
| D/C | Discharge, discontinue |
| DCS | Department of Children's Services |
| DD | Developmentally Disabled |
| DDX | Differential diagnosis |
| dept. | department |
| Des/Mtn | Desert/mountain region |
| DPG | Deputy Public Guardian |
| Dr. | Doctor |
| DR | Department of Vocational Rehabilitation |
| DIP | Drunk in Public |
| DSM-IV | Diagnostic & Statistical Manual (4th Edition) |
| DTI | Day Treatment Intensive |
| DTO | Danger to Others |
| DTR | Day Treatment Rehabilitative |
| DT's | Delirium Tremens |
| DTS | Danger to self |
| DUI | Driving under the Influence |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| DWI | Driving While Intoxicated |
| DX | Diagnosis |
| ECT | Electroconvulsive therapy |
| EEG | Electroencephalogram |
| e.g. | exempli gratia = for example |
| EKG | Electrocardiogram |
| empl. | employment |
| EPS | Extra Pyramidal Symptoms |
| ESPDT | Early Periodic Screening Diagnosis & Treatment |
| E.R. | Emergency Room |
| esp. | especially |
| etc. | et cetera |
| ETOH | alcohol |
| eval. | evaluation |
| EVRC | East Valley Recovery Center (previously Phoenix) |
| ex-hus. | ex-husband |
| EYH | Enriched Youth Home |
| ex-wife | ex-wife |
| fam. | family |
| F.I. | Financial Interviewers |
| fos.-bro. | foster brother |
| fos.-dau. | foster daughter |
| fos.-hm. | foster home |
| fos.- â / fos.-fa. | foster father |
| fos.-Ⓜfos.-mo. | foster mother |
| fos.-sis | foster sister |
| fos.-son | foster son |
| ft | feet |
| FYI | For your information |
| GA | Gamblers Anonymous |
| GAF | Global Assessment of Functioning Scale |
| GD | Gravely disabled |
| G/F | Girlfriend |
| G.I. | Gastrointestinal |
| gr.-dau. | granddaughter |
| gr.- â / gr.-fa. | grandfather |
| gr.-Ⓜ/ gr.-mo | grandmother |
| gr.-son | grandson |
| grp | group |
| grp. hm./GRH | group home |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| HCG | Human Chorionic Gonadotropin test |
| H.F. | Healthy Families Program |
| H/I | Homicidal Ideation |
| HIV | Human Immunodeficiency Virus |
| Hom. Id. | Homicidal Ideation |
| hosp. | hospital |
| hr | hour |
| H.S. | Bedtime, hour of sleep |
| ht. | height |
| hus. | husband |
| hx | history |
| IA | Interim Assistance |
| IBHS | Inland Behavioral Health Services |
| ICD-9-CM | Int'l Class. of Diseases-9-Clinical Modification |
| ICD-10 | Int'l Class. Of Diseases-10 |
| ID Notes | Interdisciplinary notes |
| IDU | Injecting drug user |
| i.e | That is |
| IEHP | Inland Empire Health Plan |
| IFP | Intensive Family Preservation Program |
| IM | Intramuscularly |
| IMD | Institute for Mental Disease |
| in | inch |
| incl. | including |
| ind | individual |
| IQ | Intelligence Quotient |
| IRC | Inland Regional Center |
| IV | Intravenous |
| IVDA | Intravenous drug abuse |
| IVDU | Intravenous drug user |
| JCAHO | Joint Commission on Accreditation of Hospital Orgs. |
| JESD | Jobs and Employment Services Department |
| JETS | Juvenile Evaluation and Treatment Services (W.V. Juv. Hall) |
| JJOP | Juvenile Justice Outpatient Program (E.V. Juvenile Hall) |
| JMHS | Jail Mental Health Services |
| L&C | Linkage & Consultation |
| LCSW | Licensed Clinical Social Worker |
| LFT | Liver function test |
| lg | large |
| LLBMC | Loma Linda Behavioral Medicine Center |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| LLUMC | Loma Linda University Medical Center |
| LMFT | Licensed MFT |
| LNMP | Last normal menstrual period |
| LOC | Location |
| LPS | Lanterman-Petris-Short Act |
| LPT | Licensed Psychiatric Technician |
| LT | Long term |
| LTO | Locked Time Out |
| LVN | Licensed Vocational Nurse |
| M.A. | Master of Arts |
| mat.-gr. â / mat.-gr.-fa. | maternal grandfather |
| mat.-gr. Ⓜ/ mat.-gr.-mo. | maternal grandmother |
| max. | maximum or maximize |
| MBMH | Morongo Basin Mental Health |
| mcg | Microgram |
| M/Cal | Medi-Cal |
| M/Care | Medicare |
| M.D. | Medical Doctor |
| MDT | Multi-Disciplinary Treatment Team |
| meds | medication |
| METRO | Metropolitan State Hospital (Norwalk) |
| MFT | Marriage & Family Therapist |
| mg | milligrams |
| mgr | manager |
| MHCI,II,III,IV | Mental Health Clinician I, II, III, IV |
| M.H.S | Mental Health Specialist |
| MHS | Mental Health Services |
| MHSIP | Mental Health Statistics Improvement Program Consumer Survey |
| MIA | Medically Indigent Adult |
| mins. | minutes |
| MJ | Marijuana |
| Ⓜ/mo | Mother |
| MR | Mental Retardation |
| MRI | Magnetic Resonance Imaging |
| M.S. | Master of Science |
| M.S.W. | Master of Social Work |
| mtg. | meeting |
| NA | Narcotics Anonymous |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| N/A | Not Applicable |
| NAPA | Napa State Hospital |
| N/B | Non-Billable |
| neg. | Negative |
| NHIC | National Heritage Insurance Company (Medicare) |
| NKA | No Known Allergy |
| no. | Numero = Number |
| noc | Night |
| NPS | Non-Public school |
| NVS | North Valley School |
| OA | Overeaters Anonymous |
| occas. | occasional(ly) |
| 1:1 | Individual therapy |
| OT | Occupational Therapist |
| OTR | Registered Occupational Therapist |
| outpt. | outpatient |
| O/V | Office Visit |
| $\overline{p}$ | After |
| pat.-gr. â/pat.-gr.fa. | paternal grandfather |
| pat.-gr. Ⓜ/ pat.-gr.-mo. | paternal grandmother |
| P.C. | Penal Code |
| P.D. | Police Department |
| PDD | Pervasive Developmental Disorder |
| PET | Psychiatric Evaluation Team |
| PET SCAN | Positron Emission Tomography Scan |
| Ph.D. | Doctor of Philosophy (psychology) |
| PHF | Psychiatric Health Facility |
| PL | Placement |
| Pl.Dev. | Plan Development |
| pl. ther. | Play therapy |
| P.M. | Post Meridiem = after noon |
| PMS | Premenstrual Syndrome |
| po | oral |
| POE | Proof of Eligibility |
| POR | Problem Oriented Record |
| pos. | positive |
| PP | parent partner |
| prn | Pro re nata = whenever necessary, as needed |
| prob. | problem |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| PSH | Patton State Hospital |
| Psych Triage | Psychiatric Triage (ARMC) |
| Psy.D. | Doctor of Psychology |
| P.T. | Psychiatric Technician |
| pt. | patient |
| pta | prior to admission |
| PTSD | Post Traumatic Stress Disorder |
| Pub. cons | Public Conservator |
| Pvt. cons | Private Conservator |
| Pvt. M.D. | Private Medical Doctor |
| Px | Prognosis |
| — | every |
| QID | Four times a day |
| R&B | Room and board |
| RCC | Redlands Counseling Center |
| RCCS | Rancho Cucamonga Counseling Services |
| RCH | Redlands Community Hospital |
| RCL | Rate Classification Level |
| re | regarding |
| rec'd. | received |
| reg. Ed. | regular education |
| rel-shp. | relationship |
| ret. | return |
| RFT | Renal Function Test |
| RGH | Riverside General Hospital |
| RN | Registered Nurse |
| R/O | Rule Out |
| ROWE | Reach Out West End |
| Rpt. | Reports |
| RSP | Resource Specialist Educational Program |
| RTC | Return to clinic |
| RWD | Recovery, Wellness, and Discovery |
| Rx | Prescription |
| 2nd CERT | Second 14 day certification |
| St. B's | St. Bernardine's Hospital |
| SACH | San Antonio Community Hospital |
| SARB | School Attendance Review Board |
| SBCDPH | San Bernardino County Department of Public Health |
| SBCH | San Bernardino Community Hospital |
| sc | Subcutaneous |
| schiz. | Schizophrenia or schizophrenic |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| SDC | Special Day Class |
| SDC | Special Day Class |
| SDI | State Disability Income |
| SED | Seriously Emotionally Disturbed |
| SELPA | Special Education Local Plan Area |
| SHAC | Shandin Hills Adolescent Center |
| S/I | Suicidal Ideation |
| sib. | sibling |
| SIR | Special Incident Report (Children in placement only) |
| sis. | sister |
| sm. | small |
| SMA | Serum Metabolic Analysis |
| SMI | Seriously Mentally Ill |
| SNF | Skilled Nursing Facility |
| S.O. | Significant Other |
| SP | Suicide precautions |
| Sp. | Spanish |
| SPAN | San Bernardino Partners Aftercare Network Program |
| SPMI | Seriously and persistently mentally ill |
| S&R | Seclusion & restraint |
| SSA | Social Security Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| SSRI | Selective Serotonin Re-uptake Inhibitor |
| ST | Short term |
| STAR | Supervised Treatment After Release |
| STAR-LITE | STAR - Less Intensive Treatment Environment |
| STAT | Immediately |
| STEP | Systematic Training for Effective Parenting |
| st.-bro. | step-brother |
| st.-dau. | step-daughter |
| st.- â / st.-fa. | step-father |
| st.-gr. Ⓜ / st.-gr.-mo. | step-grandmother |
| st. Ⓜ - / st.-mo | step-mother |
| st.-sis. | step-sister |
| st.-son | step-son |
| Svc. | service |
| Sx | symptoms |
| tab. | Tablet |

*Continued on next page*

**Abbreviations,** continued

| | |
|---|---|
| TAD-ESP | Transitional Assistance Department--Employment Services Program |
| TANF | Temporary Assistance for Needy Families |
| T.B. | Tuberculosis; tubercle bacilli |
| TBS | Therapeutic Behavioral Services |
| T/C | Telephone Call |
| TCON | Temporary Conservatorship |
| TD | Tardive Dyskinesia |
| TFT | Thyroid function test |
| ther. | therapy |
| thru | through |
| T.I.D | three times a day |
| thru. | through |
| T.I.D. | Three times a day |
| trng. | training |
| tx | treatment |
| tx. pl. | treatment plan |
| tx. pl. conf. | treatment plan conference |
| tx. tm. | treatment team |
| UBH | United Behavioral Health |
| UCCC | Upland Community Counseling Center |
| UDS | Urine drug screen |
| unk. | unknown |
| UR | Utilization Review |
| U/A | Urinalysis |
| V.A. | Veterans Administration |
| VDRL | Venereal Disease Research Laboratory |
| V/H | Visual hallucinations |
| Voc. Rehab. | Department of Vocational Rehabilitation (see DR) |
| VOL | Voluntary |
| w/ or c | with |
| WBC | White blood cells (white blood cell count) |
| W&I | Welfare and Institutions |
| w/in | Within |
| wk | week |
| W/o or s | Without |
| WNL | Within Normal Limits |
| WRIT | Writ of Habeas Corpus |
| Wt. | Weight |
| WVDC | West Valley Detention Center |
| y/o | year old |

*Continued on next page*

# Abbreviation List, Continued

**Abbreviations,** continued

| | |
|---|---|
| yr. | year |
| YSR | Youth Self Report |
| ½ bro. | Half-brother |
| ½ sis. | Half-sister |
| 1N | Primary |
| 2N | Secondary |
| 5150 | 72-hour evaluation for adults (mental illness) |
| 5170 | 72-hour evaluation for persons inebriated |
| 5250 | 14-day certification hold |
| 5585.5 | 72-hour detention-section 5150 of W&I for minors |
| c | with |
| L | Left |
| R | Right |
| | without |
| i | One tablet |
| ii | Two tablets |
| 8 | Increase |
| 9 | Decrease |
| | None |
| # | Number |
| | Plus or positive |
| | Negative |
| **&** | And |
| @ | At |
| & | Female |
| % | Male |
| *o*<br>2 | Secondary to |

# Charting Interpretation of a Service

| | |
|---|---|
| **Entry detail for interpretation of a service** | The person writing the chart note will enter, immediately following the service name (MHS-Ind. Ther.", etc.), "Interpretation provided in [Specify language] by [name of provider]". |
| **Example** | MHS-Ind. Ther. (Interpretation provided in Spanish by Adam Articulate)... |
| **Entry detail for provision of service** | Charting provision of service in a non-English language involves the person writing the chart note will enter, immediately following the service name "(Provided in [specify language])" |
| **Example** | MHS-Ind. Ther. (Provided in Vietnamese)... |

# Co-Signatures

| | |
|---|---|
| **Co-signatures required** | All of the following non-regular employee interns will have all billable chart entries co-signed by an appropriate supervisor :<br><br>• Volunteers<br>• Community Service Aides<br><br>**Note:** In the case of interns, this supervisor must be licensed. |
| **Not included** | This is not required for MFT post-degree “interns” who are DBH employees. |
| **Other entries** | Other types of entries may be signed as well, if desired. |
| **Non-licensed OT’s** | Non-licensed OT’s will have all billable chart entries co-signed until licensure is achieved, and COTA’s will have all billable chart entries co-signed by an appropriate supervisor during the first year of DBH employment. |
| **ID notes written by clerks** | Clinic Supervisors (or designees) will co-sign administrative chart closure ID notes written by clerks. |

# Corrections

**Making chart corrections**

Correcting items written or typed in the chart is done by:

- Drawing a single line through the material deleted
- Writing the replacement material next to it, with the word “error”
- Initialing the change

**Example of correction**

An example of appropriate correction is:

- ~~touched~~ fondled
  error cee

**White out**

“White out” or other means of correction should never be used in the chart.

# Legibility

**Policy**

Everything handwritten in the chart must be legible because it:

- Is useful for other clinical staff
- Can be read by auditors

**Auditors**

Auditors may disallow payment for services for which documentation is unreadable.

# Medication Support Services ID Notes – Ink Usage

| | |
|---|---|
| **Type of ink used** | Only black and blue ball-point ink will be used in the chart in order to:<br>• Minimize potential water damage<br>• Maximize copy quality for copying and microfilming |

# Persons Allowed to Chart

**Restricted charting**

Charting of the following items In outpatient charts may only be done by the assigned provider for the service or chart at issue:

- Services
- No-Shows
- Rescheduling
- Chart Closure

**Assigned providers**

The following persons are considered assigned providers:

- Clinical therapist
- Non-staff intern
- Physician
- Clinical volunteer
- Mental Health Specialist
- Nurse
- Psych Tech

**Day treatment intensive charts**

In day treatment intensive charts, only persons assigned to do so by the Clinic Supervisor or day treatment coordinator may write DTI daily or weekly summaries.

**Weekly summaries**

Weekly summaries must be written by or co-signed by an LPHA:

- M.D.
- RN.
- Licensed registered, or waivered clinician who is DTI staff or director of the program

**Other staff**

Other staff who might write notes for co-signature would include:

- O.T.'s
- Non-staff interns
- Mental Health Specialists
- Psych Techs

*Continued on next page*

## Persons Allowed to Chart, Continued

**Day Treatment Rehab Weekly Summaries**

In day treatment rehabilitative charts, only persons assigned to do so by the clinic Supervisor or day treatment coordinator may write DTR daily or weekly summaries. Staff who could write notes without co-signatures are LPHA's:

- M.D.
- R.N.
- Licensed, registered or waivered clinician
- Psych Techs
- Non-staff interns

**Other staff**

Other staff who might write notes for co-signature would included:

- O.T.
- Mental Health Specialist

# Signatures

**General requirements**

All signatures in the chart must be legible. In order to ensure legibility, the signer will print (or stamp) his/her name and title as shown in the table below. Signatures will be made with the following formats:

| Staff | Signature |
|---|---|
| Physician | John Smith, M.D. |
| Licensed Clinical Social Workers and Licensed MFCC's | John Smith, M.S.W, LCSW, or<br>• John Smith, LCSW<br>John Smith, M.A., MFCC, or<br>• John Smith, MFCC |
| Unlicensed Social Workers and Unlicensed MFCC's | John Smith, M.A. (or other degree) |
| Registered Occupational Therapists | John Smith, O.T.R. |
| Non-registered Occupational Therapists | John Smith, O.T. |
| Licensed Psychiatric Technicians | John Smith, P.T. |
| Non-licensed Psychiatric Technicians | John Smith, Psy.A. (for Psych Aide) |
| Non-staff Interns | John Smith, M.A., Psychology Intern<br>John Smith, B.S.W., Social Work Intern<br>John Smith, B.A. MFCC Trainee<br>John Smith, O.T. Intern |
| Others | John Smith, (degree if any), volunteer<br>John Smith (degree if any), County Classification |

# Time Units

**How billing is done**

Billing is done by the minute. Any number of minutes can be billed in SIMON. Bear in mind, however, that it costs the Department about four dollars to bill a service, and the current Medi-Cal reimbursement rate is around two dollars per minute.

# Activities of Clerks

| | |
|---|---|
| **Not billable** | Interactions of clerical staff with clients are never billable as Medi-Cal services. |

## Assessment

| | |
|---|---|
| **No limit** | There is no longer a limit on the number of assessment billings per episode. |

# Auditing

**Requirements**

Time for supervision on a case or for adults is not billable as a client service or as Plan Development. If auditing results in a chart note indicating a change in the services plan or direction of treatment, then the time is billable.

# Before Client Contact

**Requirements**

Billing always requires:

- An open treatment episode
- Client consent (or implied consent)

**Services before contact**

Given these requirements, services performed before the first client face-to-face contact with clinical staff is possible if the service meets the definition of a defined billing category

**Common billable categories**

The most likely categories to be billable under these circumstances are:

- MHS-PL.Dev.
- MHS-Coll.
- CM-L&C. CM-Pl.
- CM-L&C-Pl.Dev.
  (Would always require client contact.)

**Services always requiring contact**

The following services would always require client contact:

- MHS-Ass.
- MHS –Eval

# Case Management Plan Development

**Coding**

The State Rehab manual lists Case Management Plan development as part of Linkage and Consultations. CM Plan Development notes are therefore headed “CM-L&C-Pl.Dev.” and “CM-L&C-Pl. Dev. is billed using the CDI code for L&C (561). CDI code 521 is for MHS Plan Development only.

# Chart Closure

**Billing chart closure**

The billable service involved in chart closure is Plan Development, in the form of:

- Treatment planning
- Monitoring of client progress
- The following service can therefore be billed as Plan Development by clinical staff
  - Discussions regarding the decision to terminate a, as can
  - Charting the final ID note and
  - Filling out the discharge summary, as long as the summary contains some legitimate Plan Development.

**Follow-up care**

The following applies to billing for follow-up care:

| If... | Then... |
|---|---|
| You have planned some follow-up care with the client or are making a referral upon termination, and you record this in the discharge summary | It is billable. |
| You are doing a “true” termination with a client, and you decide with the client that no further treatment is needed, and you record that on the discharge summary, | It is billable |
| if the client “disappears” and you try to contact him/her, but fail, and you fill out the discharge summary, since there is not planning or monitoring that can be done, | Filling out the discharge summary is not billable. |

**Last session and discharge summary**

It is preferable that the time for filling out the discharge summary be lumped together with the last client session. Just as other charting is combined with session time for billing purposes. If this is not possible, and a discharge summary is filled out later, a separate plan development billing can be made.

# Combining Service, Charting, and Plan Development Time

**Example**

Charting time and minor plan development time occurring before, after, or during the service can be lumped in with the service as one charge.

An example of charting minor plan development time after the service is as follows:

| If the... | Then the... |
|---|---|
| Service was 50 minutes, the charting time for that session was10 minutes, and you spent 5 minutes altering a milestone at the same time, | Billing should be for 1:05 (one hour and five minutes). |

**Minor and major plan development**

The following chart contains information about minor and major plan development:

**Note:** There is no billing for Plan Development allowed for Day Treatment services.

| Type of Plan Development | Chart and Billing Procedure |
|---|---|
| Minor activities might involve minor revision of a Client Plan or planning with co-staff a particular or changed treatment approach to be used in the upcoming session ID note | Can be combined with a treatment billing. |
| Major activities, such as a team meeting or completely filling out treatment planning forms | Should be separately charted and billed. |

# Crisis Intervention

| | |
|---|---|
| **Billable time** | Consecutive crisis interventions can be billed (for up to an eight-hour total per day), as long as each note reflects that the crisis intervention was necessary and appropriate. |

# Daily Limits

| | |
|---|---|
| **Limit for billing** | A clinician cannot bill for more minutes in one day than he/she works. |

# Day Treatment

**General**

Day treatment is an all-inclusive service, meaning that:

- Staff cannot bill any day treatment time separately from the day treatment daily charge, including Plan Development
- Similarly, one cannot bill any time to day treatment for an activity, which occurs outside the scheduled day treatment day

**Plan Development**

Staff doing necessary Plan Development regarding day treatment services cannot bill those specific minutes separately from the daily day treatment charge.

**Field Trips**

Field trips occurring outside the normal day treatment half-day cannot be billed to day treatment. If during that outing time a necessary service occurred for a specific client, like crisis intervention, that service could be billed. (Also see outings below).

**Assessment**

Assessment performed with regards to day treatment can be billed as follows:

| If Assessment performed … | Then… |
|---|---|
| After the individual becomes a day treatment client it is considered part of the daily charge for day treatment, and | It cannot be separately billed. |
| Before the person is a day treatment client, | It can be billed. |

# Evaluation

| | |
|---|---|
| **Term no longer required** | This term refers only to the Community Functioning Evaluation, which is no longer required. |

# Groups

**General**

This section covers psychotherapy, Rehab/ADL, and Medication. The basic procedure is as follows:

<table>
<tr><th>Step</th><th>Action</th></tr>
<tr><td>1</td><td>Billed time for groups is the sum of the:<br><br>• Group time<br>• Charting time for all charting done by that person on group clients<br>• Associated, minor plan development time spent by that person on all group clients</td></tr>
<tr><td>2</td><td>Group size is also indicated. For a group of six clients seen for 90 minutes by two staff time would be billed as follows:
<table>
<tr><th>Therapist</th><th>Work</th><th>Time Billed</th></tr>
<tr><td>A</td><td>Assuming that Therapist A spent a total of 30 minutes in charting and 10 minutes in plan development,</td><td>Therapist A’s time would be 2:10 (90 +30+10 =130 minutes=2 hours and 10 minutes or 2:10</td></tr>
<tr><td>B</td><td>In group 90 minutes and spent a total of 20 minutes charting and 5 minutes in plan development</td><td>Therapist B’s time would be 1:55 (90+30+5=115) 115, or 1:55</td></tr>
</table></td></tr>
<tr><td>3</td><td>In the column for “Hrs.: Min.” on the ID note form, the times for all staff are listed, using their initials, plus (C=) the total number of clients that were in the group in the above example, the “Hrs.: Min.” column would contain:<br><br>• CE = 2.10<br>• BB = 1:55<br>• C = 6</td></tr>
<tr><td>4</td><td>The same numbers are listed on all of the chart notes therapist A writes, regardless of how much attention any given client received in group or how much time was spent on that individual chart. Significant amounts of time that a client was out for any of the following reasons would be subtracted from that client’s time only:<br><br>• Late<br>• Left early<br>• Was taken out of group for some other purpose</td></tr>
<tr><td>5</td><td>If there was only one therapist in this example his initials can be omitted-i.e. 2:10<br>C=6</td></tr>
</table>

*Continued on next page*

**General** (contrinued)

| Step | Action | |
|---|---|---|
| 6 | Do not add the times of therapist A and B together and enter that total anywhere. | |
| 7 | CDI. Continuing our example, on one CDI, all six clients for the group are listed. For billing purposes, it does not matter who is primary staff and who is co-staff. | |
| | **Therapist A** | **Therapist B** |
| | Enters the same 2:10 for all of the group clients, in the Duration or Primary Staff Time column. | Enters 1:55 for all of the group clients, in the Co—staff column. (See example CDI below) |

**CDI's for more than three staff**

The following considerations are made when there are three or more staff:

- Since SIMON can only register two therapists per service, a third therapist would follow the same time reporting method, but would submit his/her time on a separate CDI, listing his/her total time for all group clients, with the same total group count that is on the first CDI
- A third and fourth therapist could submit their time together on the additional CDI as staff and co-staff, etc.

**Late clients**

If a client is not present for a significant portion of the group, the time missed is subtracted from the billing for that one client. Time missed can be attributed to:

- Being late
- Being taken out of the group to see the M.D., etc.

**Example for late clients**

In the example above, if one client was 30 minutes late, then his chart note and CDI line would have:

- 1:40 (instead of 2:10) for primary staff
- 1:25 (instead of 1:55) for co-staff
- All other client's chart notes and CDI lines would still be as described above

**Clients out of group for meds visit**

In this situation, subtract the time the client is out of the group from what his/her billed time would have been had he/she been in the group the whole time (just as if the client had bee late, above.)

*Continued on next page*

**Applicability method**

This method of notating billed time for groups is applicable of all services that accept a SIMON group billing.

**Contract agencies**

Contract agencies bill only Medi-Cal clients but enter the actual group count: Medi-Cal clients plus other clients.

**Medications support groups**

Only the following persons can bill for Medication Support Services provided in a group:

- M.D.'s
- R.N's
- Psych. Tech's

The method of identifying group session time on the ID note and CDI above is applicable to ALL Groups, including MSS groups.

**Medications education groups**

Medications education can be provided either under:

- Medication Support Services
  - Billed as MSS-Meds. Ed. Group
- Rehab ADL in MHS
  - Billed as MSS-Meds Ed. Group

**Who can bill**

The following factors must be considered when billing for medications education groups:

- Only M.D.'s R.N. and Psych Techs can bill MSS
- Clinicians can only bill for medications education under Rehab/ADL
- If Alternatively

| If... | Then... |
|---|---|
| A physician and a clinician do a medications education group together, | It can be billed as Rehab/ADL with one chart note and using one CDI. OR, Alternatively, the:<br><br>• Physician could bill MSS and chart on all clients<br>• Clinician could bill Rehab/ADL (and chart on all clients.)<br>• The two of them would turn in separate CDI's billing all clients and during the total group count on both CDI's |

*Continued on next page*

**Groups with psychotherapy and MSS**

| If... | Then… |
|---|---|
| A clinician and a physician are both present for the entire group time in a group involving some medications support and some psychotherapy | The time would be divided between MHS and MSS. |
| Within a 60 minute group, the physician was doing Medication Support Services in the group with various clients for 50 minutes (not taking clients out of the group for MSS services | The clinician would bill each client for:<br>• 10 minutes for MSS Services<br>• 10 minutes of MHS group therapy plus<br>• All charting time<br>• Plus all plan development time for that MHS service<br><br>The physician:<br>• Can be included as co-therapist for that 10 minutes of therapy (if present)<br>• Would bill a 50 minute MSS group as the only staff present |

**Multi-family groups**

For this type of group, follow the procedure outlined in Parenting Groups section below.

**Parenting groups**

Parenting groups may sometimes consist of some parents without their won charts who have children with charts, plus some parents who have their own charts but who do not have children's in charts.

| If... | Then… |
|---|---|
| A parent in this group does not have a chart but has a child with a chart | The parent is billed for collateral time:<br>• The time spent on him/her in group plus<br>• Charting plus<br>• Plan development for that chart only |
| The remaining parents do have their own charts | They are billed for group for the remaining time. |

*Continued on next page*

**Computing billable time**

The sum of the actual collateral time in group (without charting or plan development) is subtracted from the group time and the remainder is used for group billing.

**Example**

For example, in a group of two parents without charts (but who had children with charts) and three who had their own charts

| If... | Then... |
|---|---|
| The group time were 60 minutes, | • The charting and plan development time for the three with their own charts 15 minutes<br>• The collateral time spent in group on the two without charts 6 and 7 minutes, respectively<br>• Their charting and plan development time 5 and 8 minutes, respectively, you would make two collateral billing, for 11 minutes (6+5) and 15 minutes (7+8) and three group billings for 1:02 (60-13+15) reported with a group count of 3<br>• Note that the group count is only the number of parents with charts and not the total number or parents |
| There is only one parent with his/her own chart (who does not have a child with a chart) | He/she will be billed for :<br>• "MHS-Ind." (rather than for group with a group count of 1), of the time spent in-group specifically on him/her<br>• Charting and minor plan development for that chart only |

**Parent and children with charts**

Parents who have their own charts and also have children with charts could be billed either way.

# Interpreter Services

| | |
|---|---|
| **Who may bill interpreting** | Interpreter services are not billable by clinical staff. Clerical staff may bill interpreting under any appropriate MAA category. |

# Lockouts

| | |
|---|---|
| **Reference** | See the attached State Manual Lockouts chart for services that cannot be billed for that session on the CDI. |

# MSS-PL. DEV. by Non-Qualified Person

| | |
|---|---|
| **Not eligible to bill** | If a person not qualified to perform medication services writes part of a Client Plan for MSS services, that person cannot bill for that work due to being not qualified for that service. |

# Multiple Staff

**Multiple staff providing service**

Service other than group may also be provided by multiple staff and billed using the staff/co-staff columns on the CDI. There would be one ID note, including the names and disciplines of all co-staff and why they were present. Notation of each staff's time on the ID note page, using their initials, is done as explained under group billing.

# Occupational Therapy

| | |
|---|---|
| **General** | OT's and non-OT's can be mixed as staff and co-staff on any of the CDI's, but see the Department's Billing and Scope of Services document for the scope of practice all persons billing. |

# Outings

**General**

Field trips, camping trips, and other outings may include billable time if they provide:

- Life skills training (rehab/ADL individual or group)
- A milieu in which therapeutic issued are addressed directly with an individual client (individual therapy) or with groups of clients (group therapy)

**Services**

In order to bill for Mental Health Services for outing with outpatient clients or for outings with day treatment clients taking place outside the normal day treatment day, there must be an approved Mental Health Services service plan in place for each client billed, with objectives to which the outing relevant.

**Charting**

The following elements are essential in charting outings:

- An outing may not be charted as if it were one long group for all clients present
- Only the time spent in an actual, defined billable activity is billable
- Clients participating in an activity group who are doing separate projects (leather, art, etc) must be billed as rehab/ADL ind. and not group, because there was no group activity
- Clients on an outing what are each doing their separate “thing” are not participating in a group for those minutes
- Each separate service and billing (individual therapy, rehab/ADL group etc.) for each separate client must have its’ own separate chart note explaining what was done during the service in attempting to further the client’s progress toward the objectives

**Audit considerations**

Auditors will be looking especially closely at the need for day treatment clients to receive additional Mental Health Services. In charting, to the extent possible, staff should indicate separately therapeutic acidities or issues that occurred during the transportation

**Billing**

Outings with day treatment clients conducted within the day treatment day are not separately billed. Outing billing will usually be for:

- Rehab/ADL group
- In some cases, rehab ADL Ind.
- Although psychotherapy services may also be provided during outings if done by qualified staff.
- If multiple services are billed for any given client, care must be taken that the billing times do not overlap (‘double-billing”).

*Continued on next page*

**How much time may be billed**

The total outing time may be billed, although times during which staff was not engaged in therapeutic activities should be subtracted from the total time before billing. These activities include:

- Meal times
- Break time
- Sleeping
- Time just watching or interacting with clients
- Non-therapeutic portions of the transportation time

**Times billed by each staff**

The times billed by each staff member for the outing may be different. Since eight hours are assume for sleep, each staff can bill for a maximum of 16 hours per day. Additionally, any time on an outing for which staff is not being compensated cannot be billed to Medi-Cal.

**Staff per group**

Because SIMON still not accept more that two staff per group billing, outing groups may be broken up into smaller units, each in the charge of two staff, multiple CDI's may be used as in a previous section.

| If... | Then... |
|---|---|
| Clients from different programs are mixed together for an outing, | They are separated by program for billing, but the total group size of the group (or sub-group) of which they were a part is used as the group count (including all clients form all programs who were in that group or subgroup), even if that is larger than the number of clients billed on that particular CDI. |

# Preparation for Treatment

**Non-billable time**

Time spent in the following activities are not billable as client services or as plan development:

- Finding a treatment space
- Procuring or preparing materials to be used in treatment
- Arranging for co-staff participation in treatment, etc.

# Psychological Testing

**Process**

All of the following activities are billed to the code for psychological testing:

- Test administration
- Scoring
- Test interpretation
- Report writing time

**Limits**

There is no limit on the number of:

- Assessments for a client
- Separate billing for a given testing episode

**Chart Notes**

Each separate billing (one for the administration, the next day for the scoring, etc.) must have a separate chart note indicating what was done.

# Reports Outside the Department

**Billable vs. Not billable**

The following provisions apply to billing when other agencies are involved:

- Linkage and Consultation may be used to link clients with needed services, including mental health and other social services
- Plan Development covers only activities relating to the planning and coordination of the mental health services themselves
- The general rule would be that if the report or form furthers the client's mental health care, it is Medi-Cal billable as Linkage and Consultation

| Billable | Not Billable |
|---|---|
| Filling out the forms for SSI | Filling out forms for Medicare |
| Filling out forms for programs like HUD and HEAP(utilities assistance) | Court reports |
| | Reports required by another agency simply for their own purpose |

# Service Location

**Service location codes**

The following provisions apply to service locations:

- There are no restrictions as to place, day, or time of day of service delivery (except for the residential services). Services may take place over the phone and/or on weekends
- The service locations on the CDI and the ID notes are the same, as follows:
    1) Clinic (DMH Site)
    2) Field/OOC/Jail (if no other codes apply)
        i. OOC stats for out-of-clinic
    3) Phone
    3) Non-Face-To-Face (preempts all other codes)
    4) Home
    5) Satellite (see Clinic Supervisor for definition
    6) School
    7) Crisis in the field
- Use the following table to determine which codes to use:

| If your service was... | Then... |
|---|---|
| Not performed face-to-face with a client or a collateral person, | Code your location first and the client's second as 3:<br>• Example, 1-3<br>• All services delivered by phone are coded X-3 |
| Performed face-to-face with a client or a collateral person, | Choose from among codes:<br>• 1,4,5,6 and 2<br>• Using code 2 only as a last resort, if no other codes apply |
| Performed as a crisis in the field, | It is preferable to code as:<br>• 4,5,6 or 2, rather than 7<br>• If it is reasonable to do so |
| If you think one of your service sites might be a satellite, | There are complex regulatory definitions, and your Clinic Supervisor should be consulted |

# Staffing or Team Meetings

**Charting with multiple staff**

It is acceptable to have one chart note, mentioning all participants, their disciplines, and why they were present, with a Plan Development billing equal to the time actually spent on that client multiplied by the number of people who actually participated in that discussion. The following scenarios are all acceptable billing:

- If a client were discussed for 6 minutes by 5 staff, it could be a single 30-minute billing by the person writing the chart note. The staff member present could divide up the clients discussed to do the chart notes (and therefore the billings.)
- An alternative procedure would be for each of the 5 staff to separately bill the 6 minutes, and to each write his/her own chart note
  - If the meeting includes only the Team Leader, and clinician (and /or the client), a single note is acceptable, with billing on one CDI as staff and co-staff.
- A third acceptable method is for one person to write a single note, mentioning the names of all actual participants, and each participant put that time 6 minutes, 9 minutes, etc. on his/her CDI without waiting a note

# Subpayee Services

| | |
|---|---|
| **Not billable** | Doing subpayee functions is not billable (but of course helping the client work on budgeting can be billed as rehab/ADL). |

# Time of Charting

**Determining charting time**

Use the following chart to determine how to bill charting time:

| If... | Then... |
|---|---|
| You can do the charting before you turn in the CDI for the service itself, | Include the charting time in that service, even though you charted on a different day.<br><br>Notes should be written no later than the next day and filed in the chart no later than 72 hours after the service. |
| You chart after you turn in the CDI with the billing for the service time itself, | Bill the charting time separately as Plan Development. Make clear on the note, however,<br>• The minutes billed for the service itself (and the date of the service)<br>• The minutes billed for the charting as Plan Development (and the date of the charting)<br>• For example, head the note itself:<br>– "7/23/06 0:06 MHS-Pl. Dev." and in the note, "This note is for 0:54 billed for Ind. ther. 7/22/06 |
| More than one service occurs in one continuous session (collateral and individual, for instance), | There should be two separate ID notes and two separate billings each of its own proper amount of charting and plan development time added, if any. |

# Travel

**How to bill travel time**

The following considerations apply to billing for travel time:

- Travel time is not billed alone but always as part of a defined client service
- The time billed for a service should be consistent with the content of the ID note
- Travel time need not be separately identified in all cases, but if travel is a large enough proportion of the total time that the actual service described in the ID note does not seem appropriate to the time billed, then the ID note should include a statement such as:
  – "40 min. travel" or "33 min. travel"
- Reporting a location other that the clinic does not imply that travel took place. Travel not connected with a charted service of some sort is not billable

# Treatment of Substance Problems

**General**

Substance diagnoses are acceptable as secondary diagnoses, but treatment services aimed primarily or substantially at the treatment of substance problems are not billable as mental health services.

# Uniformity

| | |
|---|---|
| **Time entered on CDI** | The time entered for a session on the ID note MUST be the same time that is billed for that session on the CDI. |

# Use Actual Time

**What time should be billed**

The time billed is the actual time used for billable services:

- 27 minutes (0.27), 33 minutes (0.33), etc.
- Do not use a standard session time (like 50 minutes) or a standard time for charting (like 10 minutes), but report the actual time used for that session for that client
- It is fraudulent to “pad” billing, by for example, adding 15 minutes for charting when you only spend 7 minutes charting

# Forms in Other Languages

**Purpose**

In order to promote client participation in treatment and client understanding of the care process, certain chart forms may be issued in languages other than English.

**Procedures**

The following chart details the procedures for using forms in other languages:

| Step | Action |
|---|---|
| 1 | Only translated forms issued by the Clinical Records Committee will be placed in the chart. |
| 2 | When a translated form is placed in the chart, the corresponding English version will always be filed with it. |
| 3 | In the case of those forms requiring only signatures the:<br>• English and translated versions may be copied back-to-back<br>• Translated version would be signed<br>• One not used would have a diagonal line drawn through it |
| 4 | In the case of those forms which have important content filled in, such as the Coordination Plan and Service Plan, the:<br>• Clinician will fill in the non-English version in the other language<br>• Signatures will go on the non-English version<br>• Clinician will fill out a corresponding English version which will be filed in the chart with the non-English version |

# Order of Forms in an Open Chart

**Form included** All forms that could possibly be used in an open MHS chart are listed below. To use this list as a "procedure tool" make a copy and highlight ONLY those forms that are used in your clinic charts.

| Section Number | Section Name | Form Names |
|---|---|---|
| 1 | Plans-Orders- MEDS | • Out-of-County Authorization<br>• Client Recovery Plan<br>• Care Necessity Form<br>• Diagnosis Form<br>• Approved TX Authorization Request |
| | TAB | |
| 1 | | • ALERT SHEET for Allergies (if necessary)<br>• Medication Record<br>• AIMS (Abnormal Involuntary Movement Scale)<br>• Medications Consent Form<br>• Physical Assessment form |
| 2 | ID Notes | • I.D. (Interdisciplinary Notes)<br>• Medication visit Interdisciplinary Note<br>• Services Team Actions<br>• (All I.D. Notes Chronologically)<br>• Universal Referral Form<br>• "This Chart Has Been Thinned" (a reminder) |
| 3 | Miscellaneous | • All School records-Adolescents<br>• AB 2726 Application/Agreement<br>• AB 2726 Assessment/Assessment Plan<br>• Group Home Agreement<br>• Social Security Letters of Ruling<br>• Determination, Sub-payee Orders<br>• Change in Payment form |
| 4 | Consents/MISC. | • Consent for Outpatient Treatment<br>• Med. Care Authorization for Minor<br>• Consent to Sound or Video Record<br>• Consent to Transport a Minor<br>• Behavioral Health Tele-Service Consent<br>• Release and Hold Harmless Agreement<br>• Children's Interagency Auth to Exch (PHI)<br>• Notice of Privacy Practices Acknowledgement<br>• Advanced Directives Notice<br>• Delegation of TX Consent<br>• Advance Beneficiary Notice (ABN)<br>• Placement Application |

*Continued on next page*

# Order of Forms in an Open Chart, Continued

**Form included,** (Continued)

| Section Number | Section Name | Form Names |
|---|---|---|
| 5 | Correspondence | • Legal Papers:<br>– Conservatorship, Court Orders, Guardianship<br>– Treatment Attendance letters to patient from clinic<br>– Index for Confidential Info Released<br>– Authorization to Release Confidential (PHI)<br>– (Attach copies of information released)<br>– (Attach copies of claims, form, etc.)<br>– Subpoenas-Court Orders for records |
| 6 | Divided by Tabs | • (On TOP of tab section)<br>• Client Episode Summary Form<br>• Registration Form |
| | | TAB |
| | Identification | • Face Sheet SIMON report 140<br>• Initial Contact Form<br>• Client Payment Agreement<br>• AB 2726 Liability (Adolescent) |
| | | TAB |
| | Evaluation-Admission | • Adult Clinical Assessment<br>• Client Resource Evaluation<br>• Adult Psychiatric Evaluation<br>• Child/Adol Psychiatric Evaluation<br>• Child/Adol Clinical Assessment<br>• Client Recovery Evaluation (Annual)<br>• Healthy Homes Assessment<br>• AB 2726 Clinical Assess Counseling<br>• AB 2726 Clinical Assess Assaultive Behavior Addm<br>• AB 2726 Clinical Assess Residential<br>• AB 2726 Clinical Assess Mental Status Addm<br>• AB 2726 Clinical Assess Firesetting Addm |
| | | TAB |
| | Physical | • Physical Exam (if available) |
| | | TAB |
| | Psych-Testing | • After Care or Discharge Sum (from Inpatient)<br>• Psych Testing report (if available) |
| | | TAB |
| | Clinical Lab | • Laboratory Reports (if available) |
| | | TAB |
| | X-Ray/EKG | • X-Ray & EKG reports (if available) |

*Continued on next page*

**Form included,** (Continued)

| Section Number | Section Name | Form Names |
|---|---|---|
| | | TAB |
| | Consults – Old Episodes | • All prior episodes received from DBH or copies from outside facilities may be kept here.<br>• Or, all pervious charting may be dept in a locked file in the clinic (enter "reminder" form in place of charting)<br>– "RETURN OLD CHART WITH THIS EPISODE"<br>• See Procedure 13 in this manual for sample forms and reminders |

**Changes to permanent chart forms**

All changes to permanent chart forms or their placement in the chart shall be presented for approval to the Clinical Record Committee. Clinic forms used only as "worksheets" in the open chart do not need approval.

## Useful Links

| ADP Bulletins and Letters Website |
| --- |
| http://www.adp.cahwnet.gov/ADPLTRS/bulletin_letter.shtml |
| **DMH Letters and Notices Website** |
| http://www.dmh.ca.gov/DMHDocs/default.asp?view=letters |
| **Risk Management Website** |
| http://countyline/riskmanagement/ |